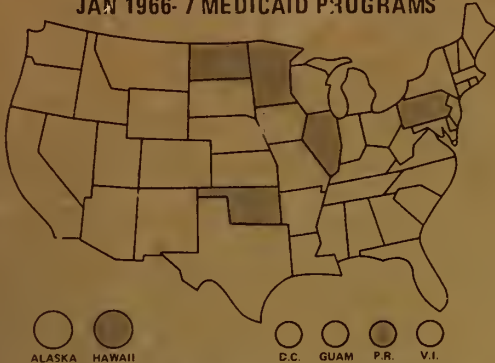


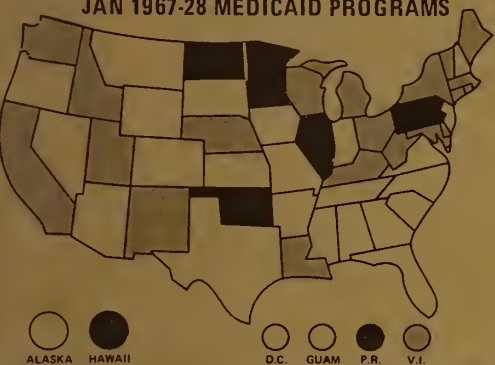
# Medicaid's 52 Programs

## CHARACTERISTICS OF STATE MEDICAL ASSISTANCE PROGRAMS UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

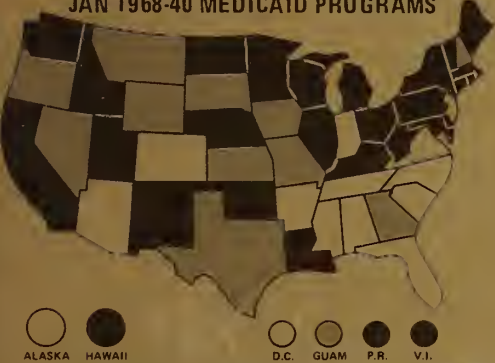
JAN 1966-7 MEDICAID PROGRAMS



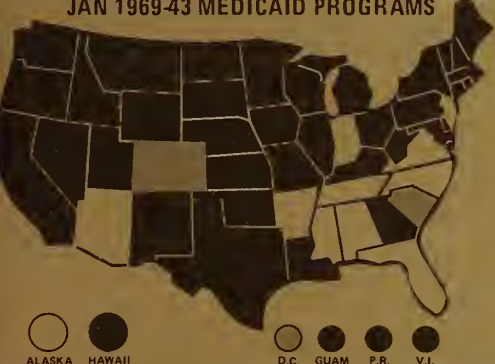
JAN 1967-28 MEDICAID PROGRAMS



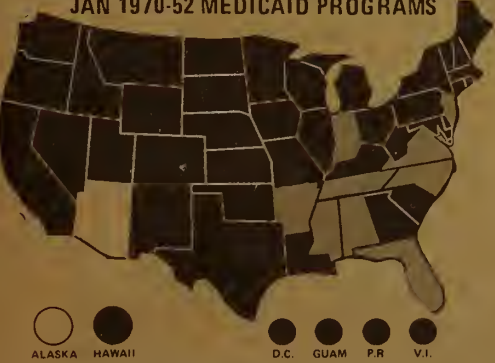
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PUBLIC ASSISTANCE SERIES  
NUMBER 49: 1970 EDITION  
DATA AS OF JANUARY 1970

# **CHARACTERISTICS OF STATE MEDICAL ASSISTANCE PROGRAMS UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**



U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
SOCIAL AND REHABILITATION SERVICE  
Assistance Payments Administration  
Medical Services Administration

A related report issued by the Social and Rehabilitation Service, United States Department of Health, Education, and Welfare:

**CHARACTERISTICS OF STATE PUBLIC ASSISTANCE PLANS: GENERAL PROVISIONS—Eligibility, Assistance, Administration (Public Assistance Report 50) 1970 Edition**; for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.



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## PREFACE

In 1970 Medicaid had a caseload of 15.5 million people.

Medical assistance authorized under Title XIX of the Social Security Act reached these 15.5 million people through 52 separate federally aided programs which vary widely in regard to content of medical and remedial care, requirements for eligibility, State agency administrative structure, and proportion of Federal, State, and local funding.

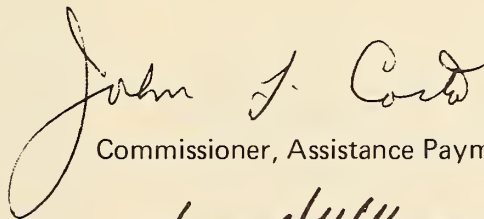
To meet the need for concise, comprehensive, and comparable information about the diverse separate programs, this publication has been prepared as a cooperative effort by the Assistance Payments and Medical Services Administrations in Washington, their colleagues in the HEW Regional Offices, and the State Agencies responsible for the program in each of the jurisdictions.

Data, all as of January 1970, come from federally approved State plans; from State laws, manuals, and other documents; and from State agency responses to a special questionnaire. In every instance the text has been reviewed and approved by the appropriate State agency.

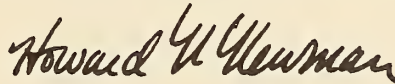
Information about each program is presented in a summary format which is explained in the "Outline of Information Reported for Each State" beginning on page xiii.

In order to help readers see Medicaid in perspective within the framework of an emerging Federal role in health care financing, we have included an introduction summarizing program developments from the first Federal financial participation in costs of medical care in 1936 to the enactment of Title XIX in 1965 and subsequent amendments.

We hope the publication will be useful to citizens who are concerned with public policy in the areas of welfare and the delivery and financing of health care services as well as to officials in Federal, State, local, and voluntary agencies who are charged with the responsibility of making health and medical care available to the most vulnerable groups in our society: the needy old, the needy blind, the needy disabled, and needy children and their families.



Commissioner, Assistance Payments Administration



Commissioner, Medical Services Administration

June 1971

## INTRODUCTION

The Medical Assistance Program, known as Medicaid, is rooted in almost thirty years of earlier Federal-State experience in paying for medical care for needy people under the public assistance programs of the Social Security Act.

This introduction briefly outlines program developments during the years preceding and following the establishment of the Medical Assistance Program in its present form.

**1936: Initiation of Federal-State programs under the public assistance titles of the Social Security Act; no provision for Federal matching of costs of medical care as such, although such costs could be included in the maintenance payments to an individual or family.**

Assistance under the Federal-State public assistance programs began in February 1936 in the form of "unrestricted money payments" to individual recipients. If the cost of needed medical care was included in a recipient's budget and payment, the amount was matchable from Federal funds just as were the costs of food and shelter. The individual's total payment was subject to State and Federal matching maximums per month per recipient.

For the first 10 years, the Federal matching formula never went higher than 50 percent of the first \$40 per month for the aged or the blind and 50 percent of the first \$18 a month for one-child plus 50 percent of \$12 a month for each additional child in a family receiving aid to dependent children.

Because of the low level of matching and the "unrestricted money payment" requirement, some States financed medical care from State or local funds and made payments to hospitals and doctors. For such payments no Federal financial participation was available.

**1950: Federal financial participation authorized in payments to suppliers of medical care and services (vendor payments) in behalf of public assistance recipients; combined money payment and vendor payment total subject to Federal matching maximum amount per month per recipient.**

After a 1950 amendment, effective October 1, 1950, a State could submit a plan for making vendor payments in behalf of recipients of assistance under one or more of the Federal-State public assistance programs for a content of care defined by the State. Within the next six years 20 States had federally approved plans for making such vendor payments. A few of these States provided only inpatient hospital care. One reason for the slow development of such plans probably lay in the fact that the Federal matching of expenditures was limited to a specified percentage of the total paid each month *to or in behalf of* the

individual recipient up to a figure called "the Federal matching maximum".

In October 1956 the Federal matching maximum was raised to \$60 in the adult categories (aid to the aged, the blind, the permanently and totally disabled). This meant that if a person received more than \$60 a month in total maintenance payments and medical vendor payments combined, State and local funds had to cover all of the amount in excess of the \$60 as well as the non-Federal share of the first \$60. In the program of aid to dependent children, matching maximum figures were lower: \$32 for one child, \$32 for one needy relative with whom the child lived, and \$23 for each additional child.

To counter the seasonal variations in medical care costs which often required heavy expenditures of State funds above the Federal matching maximum, the device of the "pooled fund" was developed. This was essentially a method of self-insurance for the State: a premium per recipient was determined upon and paid into the "pooled fund" each month. The small regular payment into the pooled fund was classified as a vendor payment in behalf of the individual recipient and counted as part of his total assistance subject to the limitations of the Federal matching maximum. The irregular and unpredictable payments made by the State out of the pooled fund to pay for his medical care were not so classified and were not subject to month-by-month limitations. Expenditures were identified as being made for the recipient in question but it was the payment into the fund rather than the payment out of the fund that was included in the amount subject to the matching maximum.

By June 30, 1957, there were pooled funds in 12 States.

**1957: Optional "\$6 - \$3" Federal matching formula for medical vendor payments separate from formula for maintenance money payments (in effect July 1, 1957, to September 30, 1958).**

A matching formula for medical vendor payments (separate from maintenance money payments) was enacted in 1956, effective July 1, 1957. It permitted Federal sharing in a State's total expenditures for vendor payments up to one-half the sum of \$6 times the number of adult recipients (including adults in aid to dependent children cases) and one-half the sum of \$3 times the number of child recipients per month. Use of this formula was optional and a State could continue to claim Federal matching on the combined money and vendor payments up to a maximum on the monthly payment to each individual.

The impact of the special incentive matching option was significant: by the end of 1958, 20 additional State departments of public welfare and four agencies administering separate programs of Aid to the Blind had federally approved plans for vendor payments.

The number of States with "pooled funds" rose to 15.



## INTRODUCTION—Continued

**1958: Federal matching formula revised to apply to average of expenditures for individual recipients, whether vendor payments for medical care or money payments for maintenance; Federal matching rate revised to vary from State to State.**

The 1958 amendment rescinded the 1956 amendment's "\$6 and \$3" matching for medical vendor payments and changed the basis for Federal sharing to include both medical vendor payments and maintenance money payments within a new general averaging formula. Since the new formula was based on *averaging* all payments instead of on a maximum related to each *individual* payment, the 1958 formula enabled States to receive Federal participation for larger medical care expenses in individual cases.

Under the new formula, the rate of Federal matching varied for the first time from State to State. The formula was based on the relationship of the average per capita income of the State to the average per capita income of the United States, with lower per capita income States receiving higher percentages of Federal participation.

By September 30, 1960, four additional States had begun federally approved vendor payment plans.

**1960: Special incentive Federal matching for medical vendor payments in behalf of public assistance recipients 65 years of age and older; optional new program for medical vendor payments in behalf of medically needy aged with new "Federal medical percentage" formula applicable to total expenditures.**

The 1960 amendment to Title I (Old-Age Assistance), known as the Kerr-Mills amendment, became effective October 1, 1960. It authorized Federal matching for an additional \$12 per recipient of OAA for expenditures in the form of vendor payments for medical care. (In 1962 the per-recipient vendor payment addition was increased to \$15 per recipient for OAA, and the increase was extended to the blind and disabled for those States electing to use the combined program—Aid to the Aged, Blind, or Disabled—under Title XVI.)

The amount was figured thus: Maximum monthly amount subject to Federal participation was \$70 multiplied by the number of recipients plus that amount above the \$70 average for all recipients which was expended for vendor medical payments up to an average of \$12 (later \$15) per recipient. These provisions applied to the 50 States and the District of Columbia. A smaller amount per recipient and a limit on the total Federal payment for such extra financial participation applied to Guam, Puerto Rico, and the Virgin Islands.

The same 1960 amendment authorized Medical Assistance for the Aged, the first public assistance program designed to serve individuals who were not financially eligible for public assistance money payments.

NAA, effective October 1, 1960, was for persons with income above a State's OAA standard of need but insufficient to meet the costs of needed medical care.

This program was limited to vendor payments. Federal financial participation was based on an adaptation of the "Federal Percentage" which was called the "Federal Medical Percentage" and was applied to open-end total expenditures rather than to individual payment maximums or the averaging of individual recipients' payments. The Federal Medical Percentage was defined in the law as follows: "Federal percent equals 100 percent minus State percent. State percent bears the same relationship between the square of average State per capita income and the square of average national per capita income for the most recent three years." The Federal Medical Percentage for any State "shall not be less than 50 percent nor more than 80 percent."

In several respects MAA led directly into Medicaid, as comparison of the laws will show. Noteworthy in this respect, in addition to complete reliance on the vendor payment method and Federal authorization of inclusion of the medically needy, are:

- the requirement that some institutional and some non-institutional care be included in a State's plan;
- prohibition of any duration-of-residence requirement for eligibility;
- prohibition of imposition of any lien against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual) and prohibition of any adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the State plan.

Under MAA, a State was required to determine a level of income which would be the test of eligibility. Some of the States set the MAA eligibility level as a maximum, i.e., a person with more income was ineligible regardless of the probable cost of the kind of medical care which he needed.

In other States, the applicant with income higher than the level set by the State was determined to be eligible on the basis of the probable cost of the care he needed. If he had need for a low-cost item of care, he might be ineligible because his income above the MAA figure could cover the cost of the care. But if he needed a higher-cost item of care, such as inpatient hospital care or nursing home care, he would be eligible because the predictable costs of the medical care would exceed the income and resources available to him to meet such expenditures. Such a recipient was expected and required to pay a portion of these costs from his excess income.

By the end of 1965, all 50 States and the 4 jurisdictions had programs of vendor payments for medical care, and 47 of the 54 had, in addition, plans for Medical Assistance for the Aged. Some of the States were providing the same scope of services in their vendor payment plans to all recipients of money payments, regardless of the public assistance category; a few States had vendor payment programs only for OAA recipients.



## INTRODUCTION—Continued

**1965: Enactment of Titles XVIII and XIX.**

Two 1965 amendments to the Social Security Act greatly expanded the role of the Federal government in health care financing.

Title XVIII established the nationwide hospital and medical insurance program popularly known as Medicare, which is administered as part of the national Social Security program.

Title XIX established the State-option medical assistance vendor payment program popularly known as Medicaid, as part of the Federal-State public assistance system.

**Adoption of Title XIX by States**

Title XIX was effective January 1, 1966. States already providing medical assistance under all the categorical programs moved quickly to submit plans under Title XIX. By January 1, 1967, 28 States had federally approved Medicaid plans in operation. By January 1968 there were 40; by January 1969, 43. On January 1, 1970, there were 52 Medicaid programs in operation, in the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and all States except Alaska and Arizona. A table of State entry dates appears on page xviii.

Under the Social Security Act amendments of 1965 (Sec. 121 of PL 89-97), Federal financial participation in vendor payments for medical care under any of the financial public assistance titles ended when a State began a program of Medicaid or in any event, not later than December 31, 1969.

**Title XIX**

The immediate objective of Title XIX was to encourage the establishment by individual States of unified single medical assistance programs under which a common content of care (including at least specified basic services) would be covered for at least everyone receiving federally aided money payments under any one of the categorical public assistance programs.

The long-term goal was to encourage States to work toward liberalizing eligibility standards and expanding the content of care with a view to providing, originally by July 1975, comprehensive services for substantially all individuals who meet the State plan's financial eligibility standards.

Federal financial participation in the expenditures for medical care and services is based on a formula like the earlier one used for the Federal Medical Percentage (related inversely to the per capita income of the State in comparison with the per capita income of the United States) except that the Federal Medical Assistance Percentage for any State "shall not be less than 50 percentum or more than 83 percentum." (Maximum matching rate under MAA's Federal Medical Percentage had not exceeded 80 percentum.) By statute, Federal funds are available on an open-end basis, just as they are for the categorical public

assistance programs for maintenance. This means that the Federal government must provide the money to match proper State expenditures made under approved State plans in accordance with the Federal Medical Assistance Percentage applicable to the State.

Medicaid, like the public assistance programs for maintenance assistance, operates through State programs based on plans submitted by each State and approved by the Federal agency as meeting the requirements of Federal law and policy. Although considerable variation is permitted from State to State in both eligibility and services, certain prohibitions apply to all States:

- No State may have a durational residence requirement. (In 1965, such requirements were common in the maintenance assistance programs and, in OAA, could be as high as 5 out of the last 9 years with 1 year immediately preceding application.)
- No State may require a lien against the property of an individual which is applicable prior to his death on account of medical assistance correctly paid or to be paid on his behalf or any recovery from his estate after his death for such assistance except for medical care received by a person age 65 or older at the time and then only with certain safeguards for the surviving widow and dependent children, if any.

For a fuller statement of these prohibited provisions and those relating to age and citizenship, refer to "Prohibited Eligibility Requirements" in the Glossary.

**Groups Eligible under Title XIX**

Within a State, all recipients of money payments under the programs of OAA, AB, APTD, AABD, or AFDC must be eligible for medical assistance (together with certain extensions of this class); and a State may choose to serve persons who would be eligible for any of these programs if they applied (see "Categorically needy" in Glossary).

If a State chooses to serve the medically needy (see Glossary), the program must cover the same groups of people which the State includes in its categorically needy class and must include persons at the defined economic level regardless of whether the basic eligibility factor is age, blindness, disability, or membership in a family meeting the definition of aid to families with dependent children. This requirement was one of the most far-reaching liberalizations of Title XIX, since the earlier program for medically needy persons applied only to those age 65 and older.

Also, whatever services are provided must be equally available to all groups of persons who are eligible under the State plan; except that, if a State wishes, the services provided to persons at the medically needy level of eligibility may be more limited in kind or in amount than the services provided to persons at the economic level of recipients of public assistance. The other exception is that the entire constellation of services under the Medicare buy-in for eligible persons 65 or older—or under the

## INTRODUCTION—Continued

screening and treatment program for eligible individuals under 21—need not be provided to individuals who are not in these groups.

### Broadened Eligibility, Mandatory and Optional

For purposes of Federal financial participation in medical care costs, eligibility for a State's Medicaid program closely parallels eligibility for its maintenance public assistance programs (see "Categorically related" in the Glossary). However, there are certain respects in which the eligibility under Title XIX is broader than eligibility for maintenance assistance:

- A State must include all children under the age of 21 who would be eligible for Federal-State assistance under the AFDC program except for age or school attendance requirements (see Glossary).
- A State may include among the groups eligible for care under the program persons who would be eligible if the State's program were as liberal as the Federal regulations permit; for example, a State which does not include aid for children of unemployed fathers in its AFDC program may include such children and their parents for medical assistance as "categorically needy," that is, eligible on the same economic level as the recipients of public assistance.

There are statutory exceptions to the general requirement that an applicant for medical assistance be "categorically related" to the basic eligibility characteristic of one of the Federal-State financial maintenance assistance programs:

- A State may include all needy individuals under 21 or "all needy children" under 21 (without regard to whether they are "deprived of parental support or care by the death, disability, or continued absence from the home of a parent" and "living with" a specified relative, which are AFDC basic requirements).
- A State may include all children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part (including non-AFDC foster care). [Some States have chosen to cover this group rather than "all needy children under 21".]
- A State may also (as a result of a 1967 Amendment) include as eligible for medical assistance "an essential person who is the spouse of a recipient of OAA, AB, or APTD," who is living with the recipient, and whose needs are included in the assistance payment, even though this "essential spouse" is not, himself or herself, aged or blind or disabled. (This extension does not apply to a spouse of a "medically needy" person.)

### Medical Services

The original Title XIX act listed 15 kinds of medical care for which Federal financial participation might be received. The last

one was "any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary" of the Department of Health, Education, and Welfare. The services later specified by the Secretary or added by amendments to the act brought the total to 21 items of medical care by January 1970. Some of the services are required of all Medicaid programs; the others are at State option. The amount, duration, and scope of a service covered by the program of a State is determined by the individual State, subject to Federal regulations. The State program summaries in this publication show the differences from State to State in the scope of each of the specific services provided by a particular State.

As the State summaries also show, the total content of care covered by the State programs varies widely from State to State. A few States limit the program to mandatory services and other States provide the whole range of services permissible under the Federal act.

### Services required by Federal law or regulation

The five services required of all State programs by the 1965 law are:

1. inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);
2. outpatient hospital services;
3. other laboratory and x-ray services;
4. skilled nursing home services (other than services in an institution for tuberculosis or mental diseases) for individuals age 21 or older;
5. physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home, or elsewhere.

Amendments in 1967 added two additional requirements for all State Medicaid programs:

- effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in the regulations of the Secretary;
- and with respect to calendar quarters beginning after June 30, 1970, home health care services for any individual who, under the State plan, is entitled to skilled nursing home services.

Transportation to and from medical care and services was added as a requirement by regulation of the Secretary in the summer of 1968, to be effective July 1, 1969, later postponed to July 1, 1970.

The full list of services which have been approved for Federal financial participation up to the date of this publication is shown



in Section B. of the "Outline of Information Reported for Each State Medicaid Program", beginning on page xiii. The kinds of services which a State has chosen to provide and the details of the amount or extent of each service are reported in the program summary pages for that State.

#### 1967 amendments

By 1967, localities, States, and the Federal Government were feeling increasingly burdened by mounting medical assistance expenditures. There was also anxiety about the quality of the long-term care being purchased with Medicaid funds.

The 1967 amendments reflect these concerns. They include changes intended to promote both short-term and long-term economy and to control the quality of care being financed in part by Federal appropriations.

Two services were added to the required list: home health care and screening, diagnosis, and treatment of children as described above.

Two kinds of review were written into the requirements: periodic medical review of the appropriateness of care being furnished to patients in long-term care institutions, and ongoing review of utilization, efficiency, economy, and quality of all care and services included under the plan.

Enrollment of eligible individuals under Title XVIII Part B (Medicare supplemental medical insurance) was encouraged by withdrawal of Federal financial participation in medical assistance costs that Medicare would have covered had the individuals been so enrolled. This provision was originally effective with respect to any calendar quarters beginning after December 31, 1967, but postponed by 1968 amendment to any calendar quarter beginning after December 31, 1969.

The 1967 amendments also revised the earlier Federal requirement that the income levels protected for maintenance in determining eligibility of medically needy persons "must be, as a minimum, at the level of the most liberal money payment standard used by the State . . . as a measure of financial eligibility in any categorical money payment program in the State." The amendment added "or at the level for which Federal financial participation is available, whichever is the less." As of

December 31, 1969, payments in behalf of needy individuals are subject to Federal financial participation only to the extent that they are made for a member of a family whose annual income level does not exceed 133 1/3% of the highest amount which would ordinarily be paid in the form of money payments to a family of similar size without any income or resources under the State's approved AFDC plan.

Federal standards were established for skilled nursing homes and States were required, effective July 1, 1970, to begin licensing programs for nursing home administrators.

Free choice among participating providers, required effective July 1, 1969, was called for by another amendment which specifically included the right to choose an organization undertaking to provide services on a prepaid basis.

Still another 1967 amendment required, effective July 1969, the training and effective use of paid subprofessional staff, with particular emphasis on recipients and other low-income people, as community service aides; and of nonpaid or partially paid volunteers in social service agencies and to assist advisory committees.

Two national advisory councils were established: The Medical Assistance Advisory Council to advise the Secretary on a continuing basis and the National Advisory Council on Nursing Home Administration to serve prior to implementation of State licensure of nursing home administrators.

#### 1969 amendments

Increasing concern about Medicaid expenditures led to further amendments in 1969.

The comprehensive care target date was postponed from 1975 to 1977, and States were relieved until 1971 of the requirement that they show progress toward meeting the goal.

A prohibition against program reduction was changed to indicate that while State financial effort must be maintained, optional items of care could be dropped if necessary because of inflated prices (provided the Secretary were assured of the adequacy of the State's utilization review procedures).

Unless otherwise identified, titles cited are from the Federal Social Security Act.

#### Abbreviations:

**AABD:** Aid to the Aged, Blind, or Disabled; Title XVI (effective October 1, 1962). An administrative plan whereby a State uses one program for aid to aged, blind, or disabled persons instead of the three separate programs of OAA, AB, and APTD (see below).

**AB:** Aid to the Blind; Title X. No Federal requirement related to age.

**AFDC, AFDC-UF, AFDC-FC:** Aid to Families with Dependent Children; Title IV-A. The needy child must be (1) deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, or, if the State so elects, the unemployment of the father (AFDC-UF) and (2) living with a relative as specified in the State plan in his or her own home or be in foster care under circumstances defined in the Federal act (AFDC-FC).

**APTD:** Aid to the Permanently and Totally Disabled; Title XIV. Federal limitation of age 18 or older.

**MAA:** Medical Assistance for the Aged, 1960 amendment to Title I, now obsolete, which permitted vendor payments for medical assistance to persons age 65 and older who were not financially eligible for assistance under the Federal-State public assistance plans but whose income and resources were such that they needed assistance with the costs of medical care. A scale of permissible income and resources had to be established by the State. These programs were obsoleted as the State began a plan for medical assistance under Title XIX; or, in a few States, before the Title XIX program went into operation, but after the enactment of the Title XVIII (Medicare) health insurance amendment began to provide similar services.

**OAA:** Old-Age Assistance; Title I. Federal requirement of age 65 or older.

#### Age or school attendance requirement:

The Federal age and school attendance requirement for AFDC eligibility (Title IV-A) is that a child aged 18 and under 21 must be regularly attending a school, college, or university, or a course of vocational or technical training designed to fit him for gainful employment.

State age and school attendance requirements for AFDC eligibility vary and in some instances limit AFDC eligibility to children under the age of 18 and, if 16 or 17, regularly attending school.

Title XIX requires States to grant Medicaid eligibility to all children under the age of 21 who, *except for Federal or State age or school attendance requirements*, would be eligible for AFDC under the State's definition.

**Categorically needy:** Financially eligible for medical assistance under Title XIX program at the same level as that for persons receiving financial assistance for maintenance in the form of money payments under the State's plan for the public assistance program through which the applicant applies.

**Categorically related:** Generally, to be eligible for Medical Assistance under this program, the person must first be subject to one of the elements identified with the four "categories of public assistance" (see below); i.e., age 65 or over, blind, permanently and totally disabled as defined by the State, or a member of a family which meets the AFDC definition. However, two specific provisions of the Federal act permit a State to extend eligibility under this term to—

(1) all "individuals" or all "children" under age 21 who meet the test of financial need (i.e., they do not have to meet the AFDC test of "deprived of parental support or care" and "living with" a specified relative), and

(2) the "essential person" who is the spouse of a recipient of OAA, AB, or APTD (see "Essential spouse").

**Categories of public assistance:** The programs of basic income maintenance authorized for Federal financial participation under the public assistance titles of the Federal Social Security Act (see OAA, AB, APTD, AABD, and AFDC in this Glossary).

**Coverage:** Word refers to the group of people who may be eligible for medical assistance under the State plan. There are three major variations among the States:

1. Some States cover only the groups mandatory under the act.
2. Some States extend coverage to elective groups for whose medical care and services Federal financial participation is available.
3. Some States also cover State-designated groups for whose medical care costs Federal financial participation is not available under Title XIX. (Administrative costs incurred for such groups of nonfederally eligible persons are subject to Federal matching although their medical care costs are not.)

In all of these situations, a State may elect to cover only those at the "categorically needy" level or it may include also the similar groups of "medically needy". However, if it includes the "medically needy" at all, it must cover all the same groups it has elected to cover as "categorically needy".

Within any one of these groups, the *individual* must meet the eligibility requirements of financial need and (except the non-federally eligible groups mentioned in paragraph 3 above) relatedness to the public assistance category through which he applies or the statutory extensions of categorical relatedness (see above).



**Essential spouse:** The spouse of a recipient of OAA, AB, APTD, or AABD who is living with and has been determined by the recipient to be essential to his or her well-being and whose needs are included in computing the assistance payment. Medicaid coverage of an "essential spouse" is at State option. (See Categorically related.)

(Unlike Medicaid, the financial assistance programs may include an "essential person" who is not a spouse.)

**Federal financial participation (FFP):** Federal contribution to total State Medicaid expenditures.

- **For costs of administration,** the Federal matching rate is 50 percent for all States.
- **For costs of professional medical personnel,** the Federal matching rate is 75 percent for all States.
- **For medical care costs,** the Federal matching rate ranges from 50 percent to 83 percent, varying from State to State in accordance with the Federal Medical Assistance Percentage (see below).

**Federal Medical Assistance Percentage (FMAP):** The rate of Federal financial participation in a State's expenditures in the form of vendor payments for medical care. As defined in Sec. 1905 (b), each State's FMAP "shall be 100 percentum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 percentum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii, except that (1) the Federal medical assistance percentage shall in no case be less than 50 percentum or more than 83 percentum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 percentum." (See inside back cover for table of Federal Medical Assistance Percentages.)

**General assistance:** Maintenance assistance or medical assistance provided under State laws and financed from State funds, local funds, or a combination of State and local funds with no Federal financial participation. In 26 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands, General Assistance is administered by or supervised by the same State agency that administers or supervises the administration of the Federal-State public assistance programs; in the other 24 States, it is administered by local units of government without State supervision and usually with only local funds.

**Medically needy:** Financially eligible for medical assistance at a level exceeding those established under the State's plan for recipients of financial maintenance assistance but insufficient to meet the costs of medical care. The State must establish standards to determine the financial eligibility of this group, i.e., a level of income which will be "protected for maintenance" (not considered available to meet the costs of medical care) and a maximum on resources that may be retained without affecting eligibility. State standards for both income and resources are subject to Federal policies and guidelines.

**Patients in public medical institutions:** Title XIX prohibits vendor payments in behalf of persons who are inmates in public institutions except as *patients in public medical* institutions. It further limits payments in behalf of patients in institutions for mental diseases or in institutions for tuberculosis to persons age 65 or older. (Titles I, X, XIV, and XVI of the Social Security Act also prohibit *money payments to* persons who are inmates in public institutions except as patients in public medical institutions; and Titles X (AB) and XIV (APTD) prohibit money payments to persons in institutions for tuberculosis or in institutions for mental diseases, regardless of age or "patient" status.)

**Prohibited eligibility requirements:** Title XIX prohibits—

- (1) a definition of "aged" requiring an age of more than 65 years;
- (2) any citizenship requirement that would bar a citizen of the United States;
- (3) any *durational* residence requirement [prior to the Supreme Court decision in *Shapiro v. Thompson*, April 1969, on this subject, such requirements were common in the categorical income maintenance programs and would have barred some needy persons from receiving medical assistance];
- (4) any lien imposed against the property of any individual prior to his death on account of medical assistance rightfully received, or any "adjustment or recovery" from his estate, after his death, for medical assistance correctly paid in his behalf, unless he is an individual who was 65 years of age or older when he received medical assistance and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or is blind or permanently and totally disabled;
- (5) any age or school attendance requirement that would bar a needy child otherwise eligible for AFDC under the State's definition (see "Age or school attendance requirement").



# OUTLINE OF INFORMATION REPORTED FOR EACH STATE MEDICAID PROGRAM IN THE PAGES FOR INDIVIDUAL STATES BEGINNING ON PAGE 1

Title of State Agency

Name of State

## A. General Information

1. Legal Base	Citation to the State law or code giving statutory authority for the State's program under title XIX.
2. Beginning Dates	Date program went into operation and date State's original plan was approved by the Federal agency.
3. Administrative Responsibility	Name of the single State agency with responsibility for the program; whether program is State-administered or State-supervised; name of other agency, if any, responsible for the determination of eligibility.
4. Historical Background	Brief summary and significant dates concerning the provision of medical and remedial care through the State public assistance programs with Federal financial participation in vendor payments made in behalf of recipients since 1950, when such participation first was authorized. (The information was taken from the files of the Assistance Payments Administration and its predecessor agencies, the Bureau of Family Services and the Bureau of Public Assistance. It was reviewed and accepted by the State agencies when the publication was prepared.)
5. Scope of Coverage	Whether program of the State covers only "categorically needy" persons or both "categorically needy" and "medically needy" persons.
6. Differences in Scope of Services Provided	Statement that the amount, duration, and scope of services provided are the same for all persons covered under the program; or that they are the same with one or more of the exceptions permitted under title XIX of the Social Security Act; i.e., those based on age (age 65, or under 65; persons under the age of 21), on financial eligibility level (more limited services to persons who are "medically needy"), or on the buy-in agreement whereby certain services which are benefits under the Medicare program (title XVIII-B) are available only to persons who are covered under the State's buy-in agreement with the Social Security Administration.

## B. Medical and Remedial Care and Services

In the items numbered 1 through 21 in this Section, the individual items of medical and remedial care and services identified in Section 1905 of title XIX, as interpreted, defined, or specified by the Secretary, are reported, together with sub-divisions where appropriate to identify sub-services or portions which may be elected separately from the other portions. For each service the following information is given:

"Not provided" or "provided"; limitations relating to persons eligible or the amount or duration of the service; requirements for prior authorization by the State or local office; basis of provider reimbursement and any restrictions on the providers to whom payment for the service will be made; who processes and who makes payment of claim for reimbursement, with distinctions as necessary if a fiscal agent processes claims but does not make payment.

1. Inpatient Hospital Services	
a. In General Hospitals	
b. In Institutions for Tuberculosis	Limited to patients age 65 or older in public and private institutions.
c. In Institutions for Mental Diseases	Limited to patients age 65 or older in public and private institutions.
2. Outpatient Hospital Services	
3. Other Laboratory and X-ray Services	(Defined as given in a setting other than outpatient hospital clinic.)

## B. Medical and Remedial Care and Services (Continued)

<b>4. Skilled Nursing Home Services</b>	
a. General	For persons of all ages; or limited to persons age 21 or older.
b. In Institutions for Tuberculosis	Limited to persons age 65 or older in public or private institutions.
c. In Institutions for Mental Diseases	Limited to patients age 65 or older in public and private institutions.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under age 21</b>	
<b>6. Physicians' Services (M.D. and D.O.)</b>	
<b>7. Services of Licensed Practitioners</b>	
a. Podiatrists	
b. Optometrists	
c. Chiropractors	
d. Other	As specified by the State.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service.</p> <p>(b) Services of Home Health Aide.</p> <p>(c) Medical supplies, equipment, and appliances.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	
<b>10. Clinic Services (Other than Hospital)</b>	
<b>11. Dental Services</b>	[For dentures, refer to item 14.c of this Section.]
<b>12. Physical Therapy and Related Services</b>	
a. Physical Therapy	
b. Occupational Therapy	
c. Speech Therapy	
d. Audiology	
<b>13. Prescribed Drugs</b>	

**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>  a. Eyeglasses  b. Hearing Aids  c. Dentures  d. Other Prosthetic Devices	
	As specified by the State.
<b>15. Family Planning Services</b>	When specified by the State as a separate service,
<b>16. Services of Christian Science Nurse</b>	
<b>17. Care and Services in Christian Science Sanatoria</b>	
<b>18. Emergency Hospital Services</b>	[Refers to services provided in a hospital which is not qualified under title XVIII or the State's title XIX program but which is used because of an emergency situation.]
<b>19. Personal Care in Patient's Home</b>	[Refers to care provided by a person who is not an RN or LPN but is certified by physician as qualified to provide the kind of service needed by the patient.]
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Services not previously identified in preceding entries which the State elects to provide, as specified.
<b>21. Transportation</b>  a. Ambulance  b. Other	

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Statement of earliest date upon which service may have been received and still be paid for in relation to date of application (i.e., within a period of time specified by the State but not to exceed a period of three months prior to the month of application, as permitted under the act) if the person was eligible for such service in the month in which it was received; except that entitlement may not begin later than the date of application for persons then eligible.
<b>2. Conditions of Eligibility (By Age Groups)</b>  a. Under Age 21  b. Age 21 to 64  c. Age 65 or older	A summary table showing the kinds of persons of specified age groups in the State's population who are eligible for services with Federal financial participation in the costs of such medical and remedial services, whether the persons are recipients of public assistance under one of the Federal-State categories or meet the financial eligibility tests for those programs, or are classified as "medically needy" because of income and resources higher than those for the public assistance categories.



### C. Eligibility for Medical Assistance (Continued)

3. Coverage of the Categorically Needy	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
a. FFP Claimed in Medical and Administrative Costs	<p style="text-align: center;"><i>Mandatory</i></p> <p>The three groups of persons which the Social Security Act requires a State to serve.</p> <p style="text-align: center;"><i>Optional</i></p> <p>The optional groups included under the act which the State has elected to serve.</p>
	<p style="text-align: center;"><i>Optional</i></p> <p>Identification of any groups that are outside the defined coverage of title XIX but are included in the State's title XIX program for which Federal financial participation in the costs of medical care is not available but for which Federal financial participation in the costs of <i>administration</i> may be, and, in fact, is claimed by the State.</p>
4. Coverage of the Medically Needy	A definition of the term "medically needy" and statement as to whether the State covers such persons.
5. Financial Criteria	The following criteria are used in establishing financial eligibility for medical assistance:
a. For Categorically Needy Persons	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
b. For Medically Needy Persons	<p>(1) <i>Income</i></p> <p>Annual income, in dollar amounts, which is protected for maintenance, according to number of persons in the family. A second paragraph reports any special provisions relating to the income level protected for maintenance of persons who are receiving <i>long term care in a medical institution</i>.</p> <p>(2) <i>Resources</i></p> <p>Provisions as to the reserve of real and personal property which may be held without affecting eligibility, with dollar amounts specified where the State sets a maximum value. The final paragraph of this item reports whether the possession of <i>excess resources</i> disqualifies the applicant, or, if not, any State provisions relating to the application of such excess resources to the cost of medical care.</p>
6. Financial Responsibility of Relatives	Provisions relating to whether the State holds any relative of a recipient of Medical Assistance responsible for the cost of medical care provided under the program, within the range permitted under the Act: spouse for spouse, parent for child under the age of 21, and parent for adult child who is blind or permanently and totally disabled.
7. Identification to Vendors of Persons Eligible	Description of identification card or other method by which an individual's eligibility for medical assistance is made known to providers of care.

### D. Administration and Management

1. Medical Assistance Unit	Organizational name of the medical assistance unit, its location within the State agency, and the staffing of the unit in terms of the professional qualifications of the director, the number and professional qualifications or affiliations of full-time staff, and the number of part-time professional staff with appropriate identification of their fields of competence.
2. Supervision of Statewide Operations	Staffing by which the Medical Assistance program is supervised in its medical aspects, and, if by a different staff or a separate agency, in its eligibility and social service aspects.

**D. Administration and Management (Continued)**

<b>3. Advisory Council</b>	Name of the State advisory body required by the Federal act for the Medical Assistance program, total number of members, how they are appointed, and number and designations of ex officio members. The entry also reports whether the authority for the body is statutory or administrative.
<b>4. Buy-In Agreement</b>	Whether State has entered into a "buy-in" agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums (for Part B- title XVIII) for persons age 65 and older, and the groups covered in such agreement.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	Responsibility of the State agency or the local agencies for the processing and payment of claims for providers of medical care; or how this responsibility is carried if the State and local agencies do not carry it directly.
<b>b. Fiscal Agents</b>	Name of the organization, if any, with whom, as fiscal agents, the State agency has entered into a contract and the responsibility assumed by such agents for processing or paying claims from providers of medical care, or from the particular providers of specified kinds of medical care covered in the contract.
<b>c. Prepaid Capitation Arrangements</b>	Name of the health insuring or similar type of organization, if any, with whom a State agency has a contract for payment of the costs of medical care through premium or per capita payments (other than through the buy-in agreement with the Social Security Administration), the services covered by such contract, and other pertinent information furnished by the State agency.
<b>d. Payments to Non-Medical Institutions</b>	Contractual arrangements with private non-medical institutions made by the State agency (or any local agency within the limits of the program if it is "State-supervised") whereby direct payments are made to the institution for costs of providing specified items of medical care and services to eligible individuals.

**E. Financing**

<b>1. Federal Financial Participation</b>	The figure, taken from official promulgation by the Secretary of the U.S. Department of Health, Education, and Welfare, as required by law, for participation from Federal funds in the cost of medical assistance provided under the program. (The Federal share of administrative costs is 50% for each State.)
<b>2. State/Local Participation</b>	Provisions for meeting the non-Federal share of the cost of medical assistance and of the cost of administration from State funds, or from a combination of State and local funds. If any local funds are used, the percentage of local funds and of State funds is reported.
<b>3. Source of State Funds</b>	Whether the State funds are derived from appropriation from State general funds, from earmarked State revenues available to the State agency without further legislative action, or from earmarked funds available only through legislative appropriation; the appropriation period; and whether the unobligated balance may be carried forward from one fiscal year or from one biennium to the next.
<b>4. Deficit Financing</b>	Provisions by which additional funds may be secured by the State if currently available State, or State and local, funds are found insufficient to meet the State's share of the cost of the program before the next appropriation period.



## TABLE OF DATES ON WHICH STATE PROGRAMS BEGAN

State	Name of Single State Agency Responsible for Medicaid Program in January 1970	Date Program Began
Alabama	State Board of Health	January 1, 1970
Arkansas	Department of Public Welfare	January 1, 1970
California	Department of Health Care Services	March 1, 1966
Colorado	Department of Social Services	January 1, 1969
Connecticut	State Welfare Department	July 1, 1966
Delaware	Department of Public Welfare	October 1, 1966
District of Columbia	Department of Public Health	July 1, 1968
Florida	Department of Health and Rehabilitative Services	January 1, 1970
Georgia	Department of Public Health	October 1, 1967
Guam	Department of Public Health and Social Services	November 1, 1967
Hawaii	Department of Social Services	January 1, 1966
Idaho	Department of Public Assistance	July 1, 1966
Illinois	Department of Public Aid	January 1, 1966
Indiana	Department of Public Welfare	January 1, 1970
Iowa	Department of Social Services	July 1, 1967
Kansas	Department of Social Welfare	June 1, 1967
Kentucky	Department of Economic Security	July 1, 1966
Louisiana	Department of Public Welfare	July 1, 1966
Maine	Department of Health and Welfare	July 1, 1966
Maryland	Department of Health	July 1, 1966
Massachusetts	Department of Public Welfare (1)	September 1, 1966
	Commission for the Blind (2)	September 1, 1966
Michigan	Department of Social Services	October 1, 1966
Minnesota	Department of Public Welfare	January 1, 1966
Mississippi	Mississippi Medicaid Commission	January 1, 1970
Missouri	Department of Public Health and Welfare (Division of Welfare)	October 13, 1967
Montana	Department of Public Welfare	July 1, 1967
Nebraska	Department of Public Welfare	July 1, 1966
Nevada	Department of Health, Welfare and Rehabilitation (Welfare Division)	July 1, 1967
New Hampshire	Department of Health and Welfare	July 1, 1967
New Jersey	Department of Institutions and Agencies	January 1, 1970
New Mexico	Health and Social Services Department	December 1, 1966
New York	Department of Social Services	May 1, 1966
North Carolina	Department of Social Services	January 1, 1970
North Dakota	Public Welfare Board	January 1, 1966
Ohio	Department of Public Welfare	July 1, 1966
Oklahoma	Department of Institutions, Social and Rehabilitative Services	January 1, 1966
Oregon	Public Welfare Division (in Office of the Governor)	July 1, 1967
Pennsylvania	Department of Public Welfare	January 1, 1966
Puerto Rico	Department of Health	January 1, 1966
Rhode Island	Department of Social Welfare	July 1, 1966
South Carolina	Department of Public Welfare	July 1, 1968
South Dakota	Department of Public Welfare	July 1, 1967
Tennessee	Department of Public Health	October 1, 1969
Texas	Department of Public Welfare	September 1, 1967
Utah	Department of Social Services	July 1, 1966
Vermont	Department of Social Welfare	July 1, 1966
Virgin Islands	Department of Health	July 1, 1966
Virginia	Department of Health	July 1, 1969
Washington	Department of Public Assistance	July 1, 1966
West Virginia	Department of Welfare	July 1, 1966
Wisconsin	Department of Health and Social Services	July 1, 1966
Wyoming	Department of Health and Social Services (Division of Health and Medical Services)	July 1, 1967

# MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Board of Health

January 1, 1970

ALABAMA

## A. General Information

<b>1. Legal Base</b>	Code of Alabama, Title 22, Section 7.
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1970. Original plan approved by the Federal agency on December 31, 1969.
<b>3. Administrative Responsibility</b>	<p>The State Board of Health serves as the single State agency with responsibility for administering the program on a State-wide basis.</p> <p>Determination of eligibility for medical assistance is made by the 67 County Departments of Pensions and Security under the supervision of the State Department of Pensions and Security.</p>
<b>4. Historical Background</b>	<p>Provisions for vendor payment of the costs of medical care as a part of the public assistance programs under the Department of Pensions and Security began in October 1960 with nursing home care under OAA. Early in the following year, hospitalization for OAA was added; and in October 1961 payment for nursing home care was extended to AB, APTD, and adults in the AFDC program. During 1961, a contract was developed with the State Department of Health to provide medical supervision and specified administrative services for the hospitalization of OAA recipients and for the newly authorized program of Medical Assistance for the Aged (for persons age 65 and older who were not recipients of public assistance but met certain criteria of financial and medical need).</p> <p>This Federal-State program, beginning in February 1962, provided in-patient hospital care and physicians' services for a brief time after a period of hospital care. A similar scope of physicians' services was added to the OAA program simultaneously. In January 1963, routine quarterly physician visits to OAA recipients in nursing homes was added.</p> <p>When the amendment to the Social Security Act later in 1962 permitted continuing AFDC-FC payments to children who had been removed from their homes by court order and placed in foster homes, the State was permitted to include this group of children in the vendor payment plan since it had formerly been providing such care without Federal financial participation. The services were inpatient hospitalization, physicians' services, certain dental care, and limited nursing care in the home under specified conditions. Such medical care was never extended to child recipients of AFDC under the regular program.</p> <p>With the beginning of Medicare (title XVIII of the Social Security Act) in July 1966, the scope of services in both OAA and MAA were greatly modified to correlate them with services available to aged persons under Medicare. The MAA program was discontinued in May 1969; services under the public assistance categories continued until the beginning of the Medicaid program.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis are provided only for patients who are 65 years of age or older. (Item B.1.b.)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.a.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available on a more liberal basis to individuals covered by the State's buy-in agreement. (Item B.6.)</p>



## B. Medical and Remedial Care and Services

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to 60 days per calendar year. No requirements for prior authorization. Medicare deductible and coinsurance paid through underwritten insurance policy with Blue Cross-Blue Shield of Alabama. Other claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Alabama).</p> <p>Provided. Limited to persons age 65 or older who are patients in public and private institutions. Limited to 60 days per calendar year. No requirements for prior authorization. Reimbursement on basis of reasonable cost (as paid by Social Security Administration under title XVIII). Medicare deductible and coinsurance paid through underwritten insurance policy with Blue Cross-Blue Shield of Alabama. Other claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Alabama).</p> <p>Not provided.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of customary and reasonable audited costs. Medicare deductible and coinsurance for SMI enrollees paid through underwritten insurance policy with Blue Cross-Blue Shield of Alabama. Other claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Alabama).</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of customary and reasonable charges. Medicare deductible and coinsurance for SMI enrollees paid through underwritten insurance policy with Blue Cross-Blue Shield of Alabama. Claims for services provided to persons age 65 or older who are not SMI enrollees processed and paid by fiscal agent (Equitable Life Assurance Society). All claims for persons under age 65 processed and paid through underwritten insurance policy with Equitable Life Assurance Society.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>        <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to persons age 21 or older. No other limitations. Prior authorization by State office required for extensions beyond 90 days. Reimbursement on basis of negotiated charge. Maximum vendor payment \$270 per month with supplementation (direct payment to nursing home) from relatives or other third parties permitted up to maximum rate of \$375 per month. Medicare coinsurance paid through underwritten insurance policy with Blue Cross-Blue Shield of Alabama. Other claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Alabama).</p> <p>[For AB and APTD recipients under age 21, monthly assistance payment to recipient may include an amount budgeted for nursing home care. Monthly assistance payment to adult recipients in cerebral palsy treatment centers also may include an amount budgeted for nursing home care.]</p> <p>Not provided.</p> <p>Not provided.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Provided. Prior authorization by State agency required for more than one such diagnostic work-up per calendar year. Reimbursement on basis of customary and reasonable fees as defined by Federal regulations. Claims processed and paid by fiscal agent (Equitable Life Assurance Society).</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>6. Physicians' services (M.D. and D.O.)</b>	<p>Provided. Unlimited services for recipients covered by State's buy-in agreement. For other persons, unlimited services in an acute illness; for stable chronic illness, limited as follows: (a) One visit per day during short-term stay in general hospital, (b) one visit per month in extended care facility or skilled nursing home, (3) two visits per month in unskilled nursing home, intermediate care facility, and elsewhere. No requirements for prior authorization. Reimbursement on basis of reasonable charges; payment not to exceed 75th percentile of ranges of customary fees existing in Alabama as of January 1, 1969. Medicare deductible and coinsurance for SMI enrollees paid through underwritten insurance policy with Blue Cross-Blue Shield of Alabama. Claims for services provided to persons age 65 or older who are not SMI enrollees processed and paid by fiscal agent (Equitable Life Assurance Society). All claims for persons under age 65 processed and paid through underwritten insurance policy with Equitable Life Assurance Society.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>  <b>b. Optometrists</b>   <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Not provided.</p> <p>No limitations. Prior authorization by State agency required for services in a calendar year in excess of one complete work-up, one pair of eyeglasses, and one follow-up visit (for purpose of recheck and adjustment of prescribed lenses). Reimbursement for optometric services on basis of customary, reasonable fees not to exceed \$25 per work-up; for eyeglasses, on basis of negotiated charge not to exceed \$25 per pair of glasses. (When fitting and adjustment of glasses are performed by an optician, he may be paid up to \$5 of the customary, reasonable fee paid the provider.) Claims paid through underwritten insurance policy with Equitable Life Assurance Society.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided for "house-bound" patients age 21 or older. As furnished by a home health agency, visiting nurse association, or similar organization with whom the Medical Services Administration has a contractual agreement. 100 visits per year (in combination with all other visits from home health agency for provision of authorized services). No requirements for prior authorization. Reimbursement on basis of reasonable costs (Title XVIII determined). Deductible and coinsurance paid on Medicare/Medicaid eligibles through underwritten policy with Blue Cross-Blue Shield of Alabama. Other claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Alabama).</p> <p>(b) Services of home health aide. Provided. Limited to "house-bound" persons age 21 or older. As furnished by home health agency, visiting nurse association or similar organization with whom the Medical Services Administration has a contractual agreement. 100 visits per year (in combination with all other visits from home health agency for provision of authorized services). No requirements for prior authorization. Reimbursement on basis of reasonable costs (Title XVIII principles and standards). Deductible and coinsurance paid on Medicare/Medicaid eligibles through underwritten policy with Blue Cross-Blue Shield of Alabama. Other claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Alabama).</p> <p>(c) Medical supplies, equipment, and appliances. Not provided.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital Clinics)</b>	<p>Not provided.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>11. Dental Services</b>	Not provided.
<b>12. Physical Therapy and Related Services</b>	
a. Physical Therapy	Not provided.
b. Occupational Therapy	Not provided.
c. Speech Therapy	Not provided.
d. Audiology	Not provided.
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs prescribed by a physician. No limitations. Prior authorization by State agency required for drugs not included in the Alabama Drug Code Index. Reimbursement to retail outlets on basis of actual cost (to be published in a formulary) plus a dispensing fee (for non-legend drugs, fee may not exceed 50% of drug cost); to physicians on basis of actual cost of drug plus actual dispensing cost. Claims processed and paid by fiscal agent (State National Bank of Alabama.)
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Provided. No limitations. Prior authorization by State agency required for more than one pair of eyeglasses plus frames per calendar year. Reimbursement on basis of negotiated charge not to exceed \$25 per pair of eyeglasses. Claims paid through underwritten insurance policy with Equitable Life Assurance Society.
b. Hearing Aids	Not provided.
c. Dentures	Not provided.
d. Other Prosthetic Devices	Provided. Limited to internal, life-supporting prostheses while hospitalized. Payment based on reasonable cost (as paid by Social Security Administration under Title XVIII). Medicare deductible and coinsurance paid through underwritten insurance policy with Blue Cross-Blue Shield of Alabama. Other claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Alabama).
<b>15. Family Planning Services</b>	Not provided.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. When medically necessary to prevent death or serious impairment to health, and until patient can safely be moved to a qualified hospital. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (as paid by Social Security Administration under Medicare). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Alabama).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>21. Transportation</b>	
a. Ambulance	Not provided.
b. Other	Not provided

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a., below:
a. Under Age 21	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition) and age 16 or older.</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p>
b. Age 21 to 64	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
c. Age 65 or older	(1) Individual who has attained age 65.
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
a. FFP Claimed in Medical and Administrative Costs	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p>
b. FFP Claimed in Administrative Costs Only	<p style="text-align: center;"><i>Optional</i></p> <p>None.</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>4. Coverage of the Medically Needy</b>	Not included.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	Not applicable.
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.
<b>7. Identification to Vendors of Persons Eligible</b>	A plastic identification card is issued by the State agency to each person who is certified as being eligible for the Medicaid program. For those categories (OAA, AB, APTD) where individuals are expected to be in the program for an extended period of time, the expiration date is twelve months from the month of issue. The identification card for the AFDC group has no expiration date; however, additional identification is required in the form of a paper card that is issued monthly to each family that receives a check. The plastic card is used as an imprinting device in connection with the dispensing of prescribed drugs. Pharmacies rent imprinters from the State, on a monthly basis, for use with the plastic cards. The expanded use of imprinters and cards by other vendors is anticipated to occur as the Medicaid program progresses.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Medical Services Administration (medical assistance unit) of the Department of Public Health has a physician (M.D.) as the full-time director. Other full-time staff are: 2 physicians (M.D.) as Chief and Deputy Chief of the Professional Division, 1 Associate Director (Hospital Administration), 1 Nursing Consultant (Grad. R.N.) and 3 other nursing consultants (R.N.), 2 Pharmacists (Grad. Pharmacist), and 2 accountants. In addition a pharmacist consultant and dentist consultant serve part time.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations relating to medical aspects of the program is accomplished directly through central office staff of the State Board of Health. The State Department of Pensions and Security exercises Statewide supervision over the determination of eligibility through its regular field staff.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Advisory Committee. It is composed of 21 members appointed by the State Board of Health. There are 2 ex officio members. (Commissioner, Department of Pensions and Security, and State Health Officer, Department of Public Health). Authority for the Committee is administrative.
<b>4. Buy-in Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	State agency does not directly engage in the day-to-day processing and payment of vendor claims, but fulfills its administrative responsibility for such operations through the medium of fiscal agent and insurance contracts.

**D. Administration and Management (Continued)**

<b>5. Claims Payment Process</b>	
<b>b. Fiscal Agents</b>	<p>State agency has entered into 3 fiscal agent contracts, as described below:</p> <p>(1) Blue Cross-Blue Shield of Alabama: Processing and payment of all claims (except those for Medicare deductibles and coinsurance) for inpatient hospital services in general hospitals and institutions for tuberculosis, outpatient hospital services, and skilled nursing home services.</p> <p>(2) Equitable Life Assurance Society: Processing and payment of all claims for services provided to persons under age 21 in connection with early and periodic screening and diagnosis and treatment of conditions found; also, all claims for physicians' services and "other" (i.e., non-hospital) laboratory and X-ray services provided to persons over age 65, who are not SMI enrollees.</p> <p>(3) First National Bank of Alabama. Processing and payment of claims for prescribed drugs.</p>
<b>c. Prepaid Capitation Arrangements</b>	<p>State agency purchases certain medical services through the following underwritten insurance policies:</p> <p>(1) Blue Cross-Blue Shield of Alabama. Policy covers the full amount of all deductibles, except the first 3 pints of blood, and all coinsurance, except for extended care, for obligations incurred by recipients age 65 or older under Parts A and B of Medicare. Premium payment at rate of \$5.35 per month.</p> <p>(2) Equitable Life Assurance Society. Policy covers payment of claims for physicians' services and "other" (i.e., non-hospital) laboratory and X-ray services provided persons under 65 years of age; also, claims for optometric services and eyeglasses provided to all eligible recipients. Monthly premium payments are listed as follows: Physicians' services—\$6.50; laboratory and X-ray services—35 cents; Optometric services and eyeglasses—\$1.35.</p>
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Alabama, as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 78.54.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially from State General Fund. Balance may not be carried over within the biennium but reverts to the General Fund at the end of each fiscal year unless there has been some special authorization for carrying over the funds.
<b>4. Deficit Financing</b>	There is no provision for deficit financing, at this time. If additional funds are needed before the next appropriation period, the program must be curtailed or an additional appropriation be obtained from the State Legislature.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

ARKANSAS

**A. General Information**

<b>1. Legal Base</b>	Arkansas Statutes (1947), Section 83-162 [added by Acts 1965 (2nd. Ex. Sess.), No. 14, Section 7.]
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1970. Original plan approved by the Federal agency on December 31, 1969.
<b>3. Administrative Responsibility</b>	The Department of Public Welfare serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices (75 county departments of public welfare).
<b>4. Historical Background</b>	Provisions for vendor payments for specified kinds of medical care have been in effect for recipients of OAA, AB, APTD, and AFDC since 1957. During the period September 1961 through December 1969, the State also maintained a program of Medical Assistance for the Aged (MAA), a Federal-State program for payments to providers of medical care in behalf of persons age 65 and over who were not recipients of public assistance but met certain prescribed conditions of financial and medical need. The two programs were as broad in scope as statutory authority permitted, but from time to time limitations on amount or duration of services were imposed because of financial restrictions. The services were inpatient hospital services, nursing home care, physicians' services, and basic dental care. The MAA program and the services to recipients of OAA were greatly modified in July 1966 when services under the title XVIII Medicare program became available to aged persons.
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available under the program is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B.7.a., B.8., B.12., B.14.d.)</p> <p>Certain services provided to all recipients are made available on a more liberal basis to persons covered by the State's buy-in agreement. (Items B.2., B.3., B.6.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	<p>Provided. Unlimited at University Hospital in Little Rock, Arkansas. Care in other hospitals limited to 20 days per year, with provision for extension based on medical necessity. Prior authorization for extensions required from State office. Reimbursement on basis of reasonable cost (interim payment with retroactive adjustment). Claims processed and paid by State Department of Public Welfare.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>2. Outpatient Hospital Services</b>	Provided. Unlimited services provided for persons covered by State's buy-in agreement. For all others, limited to 3 visits per year with provision for extension based on medical necessity. Prior authorization for extensions required from State office. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.
<b>3. Other Laboratory and X-ray Services</b>	Provided. Unlimited services provided for persons covered by State's buy-in agreement. For all others, limited to first \$50 per year with provision for extension based on medical necessity. Prior authorization for extensions required from State office. Reimbursement on basis of usual, customary, and reasonable charge, but not in excess of charges prevailing in the community where services are rendered. Claims processed and paid by State Department of Public Welfare.
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. Limited to persons age 21 or older. No limitations. No requirements for prior authorization. Reimbursement on basis of negotiated rate. Supplementation from relative or other third party permitted up to \$75 per month. Claims processed and paid by State Department of Public Welfare.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. Unlimited services for persons covered by State's buy-in agreement. For all others, unlimited Physicians' visits to hospital inpatients; other visits limited to 12 per year, with provision for extension based upon medical necessity. Prior authorization for extensions required from State office. Reimbursement on basis of usual, customary, and reasonable charges, but not in excess of charges prevailing in community where services are rendered. Claims processed and paid by State Department of Public Welfare.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Limited to persons age 65 or older included in State's buy-in agreement and to services provided as benefits under Medicare (Part B); routine foot care excluded. No requirements for prior authorization. Reimbursement on basis of usual and customary charges as established by Medicare. Claims for deductible and coinsurance amounts not paid by Social Security Administration are processed and paid by State Department of Public Welfare, up to the limit on units of service provided under State title XIX plan.

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Optometrists</b>	Not provided.  [Exception: Payment will be made for corrective glasses following cataract surgery.]
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. Limited to persons age 65 or older included in State's buy-in agreement; within maximum of 100 visits per year from a home health agency, as provided under Part B, Title XVIII (Medicare). Reimbursement on basis of usual and customary charges as established by Medicare. Claims for deductible and coinsurance amounts not paid by Social Security Administration are processed and paid by State Department of Public Welfare, up to the limit on units of service provided under State title XIX plan.</p> <p>(b) Services of home health aide. Provided. Limited to persons age 65 or older included in State's buy-in agreement; within maximum of 100 visits per year from a home health agency, as provided under Part B, Title XVIII (Medicare). Reimbursement on basis of usual and customary charges as established by Medicare. Claims for deductible and coinsurance amounts not paid by Social Security Administration are processed and paid by State Department of Public Welfare, up to the limit on units of service provided under State title XIX plan.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. Limited to persons age 65 or older included in State's buy-in agreement; consisting of rental or purchase of durable equipment and other items available as benefits under Part B, Title XVIII (Medicare). Reimbursement on basis of usual and customary charges as established by Medicare. Claims for deductible and coinsurance not paid by Social Security Administration are processed and paid by State Department of Public Welfare, up to the limit on units of service provided under State title XIX plan.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	Not provided.
<b>11. Dental Services</b>	<p>Provided. Examination, consultation, extractions, and palliative treatment on an outpatient basis provided without limitations or requirement for prior authorization. Orthodontic care, restorative dentistry, and other special dental procedures provided when recommended by dentist as needed for client's health and general welfare or to return him to employment; prior authorization for these procedures and for oral surgery (on inpatient hospital or outpatient basis) required from State agency. Reimbursement on basis of usual, customary, and reasonable charges, but not in excess of charges prevailing in community where services are rendered. Claims processed and paid by State Department of Public Welfare.</p>
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	<p>Provided. Limited to persons age 65 or older included in State's buy-in agreement; and limited to services available as benefits under Part B of Title XVIII (Medicare). No requirements for prior authorization. Reimbursement on basis of usual and customary charges as established by Medicare. Claims for deductible and coinsurance amounts not paid by Social Security Administration are processed and paid by State Department of Public Welfare, up to the limit on units of service provided under State title XIX plan.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Occupational Therapy</b>	Provided. Limited to persons age 65 or older included in State's buy-in agreement; and limited to services provided by a qualified home health agency, within maximum limit of 100 visits per year for all home health agency visits. Reimbursement on basis of usual and customary charges as established by Medicare. Claims for deductible and coinsurance amounts not paid by Social Security Administration are processed and paid by State Department of Public Welfare, up to the limit on units of service provided under State Title XIX plan.
<b>c. Speech Therapy</b>	Provided. Limited to persons age 65 or older included in State's buy-in agreement; and limited to services provided by a qualified home health agency, within maximum limit of 100 visits per year for all home health agency visits. Reimbursement on basis of usual and customary charges as established by Medicare. Claims for deductible and coinsurance amounts not paid by Social Security Administration are processed and paid by State Department of Public Welfare, up to limit on units of service provided under State title XIX plan.
<b>d. Audiology</b>	Not provided.
<b>13. Prescribed Drugs</b>	Not provided.  [Exception: Drugs for treatment of glaucoma are provided.]
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Not provided.  [Exception: Corrective glasses after cataract surgery are provided.]
<b>b. Hearing Aids</b>	Not provided.
<b>c. Dentures</b>	Provided. No limitations. Prior authorization by State office required. Reimbursement on basis of usual, customary, and reasonable charges, but not in excess of charges prevailing in community where services are rendered. Claims processed and paid by State Department of Public Welfare.
<b>d. Other Prosthetic Devices</b>	Provided. Limited to persons age 65 or older included in State's buy-in agreement. Devices to replace all or part of an internal organ, and other devices available as benefits under Part B of Title XVIII (Medicare). Reimbursement on basis of usual and customary charges as established by Medicare. Claims for deductible and coinsurance amounts not paid by Social Security Administration are processed and paid by State Department of Public Welfare, up to the limit on units of service provided under State title XIX plan.
<b>15. Family Planning Services</b>	Not provided.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Not provided.



## B. Medical and Remedial Care and Services (Continued)

19. Personal Care Services In Patient's Home	Not provided.
20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services	Not provided.
21. Transportation	
a. Ambulance	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charge. Claims processed and paid by State Department of Public Welfare.
b. Other	Provided. By licensed public carrier. Including lodgings when transported to University Hospital at Little Rock, Arkansas. No Limitations. Prior authorization required from local office. Reimbursement on basis of reasonable charge. Claims processed and paid by State Department of Public Welfare.

## C. Eligibility for Medical Assistance

1. Date of Entitlement	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month prior to the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
2. Conditions of Eligibility (By Age Groups)	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.
a. Under Age 21	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Child in foster home or private institution for whom the State Department of Public Welfare has legal custody and has assumed financial responsibility in whole or in part. (Including non-AFDC foster care.)</p> <p>(4) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(5) Person who is blind (State definition) and age 16 or older.</p> <p>(6) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of AABD.</p>
b. Age 21 to 64	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent. (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of AABD.</p>
c. Age 65 or older	(1) Individual who has attained age 65.



**D. Administration and Management (Continued)**

<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the activities of 14 field supervisors of the Family and Childrens' Services Program Division, State Department of Public Welfare, who are primarily concerned with the eligibility aspects of the program in the specific geographic areas to which they are assigned. Supervision and direction of the medical aspects of the program are handled directly by the staff of the Medical Services Division of the State office.
<b>3. Advisory Council</b>	As of January 1, 1970, arrangements had not yet been completed for establishment of a Medical Advisory Committee. On a temporary basis, until members have been appointed and the Committee has become fully operational, the State agency is utilizing the services of the Executive Committee of the Arkansas Medical Society, the Dental Society, and the Arkansas Hospital Association.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Public Welfare reviews, processes, audits and pays all vendor claims for medical care and services provided under the program.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Arkansas as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 79.76.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially. Unobligated balance may be carried over within the biennium, but reverts to the General Fund at the end of the biennium.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, the program must be curtailed or a special session of the State Legislature be called to appropriate additional funds.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health Care Services

January 1, 1970

CALIFORNIA

**A. General Information**

<b>1. Legal Base</b>	California Welfare and Institutions Code, Division 9, Part 3, Chapter 7 (commencing with section 14000) and Chapter 8 (commencing with section 14500), as enacted by Chapter 4, Stats. 1965, Second Extra. Sess.
<b>2. Beginning Dates</b>	Program went into operation on March 1, 1966. Original plan approved by the Federal agency on May 9, 1966.
<b>3. Administrative Responsibility</b>	<p>The Department of Health Care Services (a component of the Human Relations Agency) serves as the single State agency with responsibility for supervising the administration of the program on a Statewide basis through a system of county offices.</p> <p>The Department of Social Welfare, which supervises the administration of the State's program under title I, is responsible for certification of eligibility.</p>
<b>4. Historical Background</b>	<p>Payments to suppliers of medical care with Federal financial participation under the public assistance programs began in October 1957 for OAA, AB, and AFDC. In October 1959, coverage was extended to the APTD program. Since inpatient hospital care was available through county hospitals, the program paid for outpatient services, practitioner fees, dental care, and drugs (on a formulary) for public assistance recipients in adult categories and for AFDC children. AFDC parents were covered only for emergency dental services and outpatient rehabilitation services. Some other medical services were recognized in the State plan and were allowed for within the money payment to the recipient, subject to the maximum on the total payment covering subsistence and medical needs. The program was financed through monthly payments per recipient, on a basis established by State statute, into a Medical Care Premium Deposit Fund. Federal, State, and county funds were involved. Claims for services were paid from this Fund.</p> <p>Legislation in 1961, effective in January 1962, authorized participation in the Federal-State program of Medical Assistance for the Aged (MAA), a program designed for persons age 65 and older who were not recipients of public assistance but met other criteria of financial and medical need. The scope of services included inpatient hospital care (after a 30-day period of care in a county hospital), nursing home care, and, for patients who had been discharged from a period of institutional care, practitioners' services, dental care, pharmaceutical services, and outpatient services including prostheses and therapeutic X-rays. Both State and local funds were used to meet the non-Federal share of institutional care, and State funds only for the non-institutional kinds of services.</p> <p>Because of the existence of this MAA program, the scope of inpatient hospital care and nursing home care paid for under the OAA and APTD programs was limited for persons age 65 and older; but for recipients under age 65 (AB and APTD), such services were included in the federally-aided vendor payment program. Special hospitalization for dental, eye care, and rehabilitation services for recipients of any age under all three public assistance categories was paid for by vendor payments under the categories. The other services were not affected by this age-break.</p> <p>These programs continued in operation until the beginning of the Medical Assistance program under title XIX in 1966.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.; B.4.b. and c.)</p> <p>Certain services provided for categorically needy persons are made available on a more limited basis to medically needy persons. (Items B.6, 7, 8, 11, 12, 13, 14, 16, 21.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>          <b>b. In Institutions for Tuberculosis</b>          <b>c. In Institutions for Mental Diseases</b>	<p>Provided. No limitations. Prior authorization by local Medi-Cal consultant required (except where services received are compensable under Medicare) for extension beyond 8 consecutive days in a non-county or non-State hospital; maximum extension of 30 days; authorization granted only if transfer to a county facility would endanger patient's life, or if a bed or needed services are not available in a county facility. No requirements for prior authorization for stay in a county or State hospital. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Hospital Service of California <i>or</i> Hospital Service of Southern California).</p> <p>Provided. Limited to patients age 65 or older in public or private institutions for tuberculosis. No other limitations. Prior authorization by local Medi-Cal consultant required for extension beyond 8 consecutive days in a private institution or general hospital; with 30-day maximum per increment of extension. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Hospital Service of California <i>or</i> Hospital Service of Southern California).</p> <p>Provided. Limited to patients age 65 or older in State mental institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of average per diem cost of all participating facilities in the State mental hospital system. Claims processed and paid by State Department of Health Care Services.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (itemized) or cost per clinic visit concept. Claims processed and paid by fiscal agent (Hospital Service of California <i>or</i> Hospital Service of Southern California).</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>          <b>b. In Institutions for Tuberculosis</b>          <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For persons of all ages. No limitations, but service must be ordered by attending physician. Authorization by local Medi-Cal consultant required (except for Medicare-covered period of stay); request must be submitted and received within 10 days following date of admission. Initial authorization may be granted up to end of second month following month of admission; subsequent reauthorizations must be obtained at least every 3 months. Reimbursement on basis of maximum per diem rate not to exceed \$14. Claims processed and paid by fiscal agent (Hospital Service of California <i>or</i> Hospital Service of Southern California).</p> <p>Provided. Limited to patients age 65 or older in public or private institutions. Prior authorization by local Medi-Cal consultant required for extension beyond 8 consecutive days in a private institution or general hospital; with 30-day maximum per increment of extension. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Hospital Service of California <i>or</i> Hospital Service of Southern California).</p> <p>Provided. Limited to persons age 65 or older in State mental institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by the State Department of Health Care Services.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Not provided.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. No limitation on services for categorically needy. Eye refractions for medically needy provided only within 90-day period following institutional inpatient care when service is related to or affects the disability which required such inpatient care (limitation not applicable when service available to patient as a Medicare benefit). No other limitations. Prior authorization by local Medi-Cal consultant required (except where service is available to recipient as a Medicare benefit) for procedures involving treatment of cosmetic defects (approval granted only in special cases of serious disfigurement) and for more than 5 psychiatric outpatient visits in a 6-month period; each authorization limited to maximum of 90 days or 10 visits, whichever occurs first (additional visits require a new authorization). Reimbursement on basis of usual, customary, and reasonable charges; payment not to exceed product of application of 60th percentile conversion factor (based on January-March 1967 data) to 1964 California Medical Association Relative Value Studies. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	<p>Provided. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to or affects the disability which required such inpatient care (limitation not applicable when services are available to patient as a Medicare benefit). No other limitations. No requirements for prior authorization. Reimbursement as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>b. Optometrists</b>	<p>Provided. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to or affects the disability which required such inpatient care. No other limitations. Prior authorization by local Medi-Cal consultant required for all services other than eye examinations and refractions. Reimbursement as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>c. Chiropractors</b>	<p>Provided. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to or affects the disability which required such inpatient care. No other limitations. No requirements for prior authorization. Reimbursement as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>d. Other</b>	<p>Provided. Services of licensed psychologist, on written prescription of a physician. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional care when service is related to or affects the disability which required such inpatient care. No requirements for prior authorization for services provided (1) to inpatient in hospital or rehabilitation center, (2) by or through an organized hospital outpatient service or rehabilitation center outpatient service, or (3) to patient in a nursing home when included in home's cost payment formula. Otherwise, prior authorization by local Medi-Cal consultant required for services in excess of 6 visits or treatments rendered on separate occasions during a 6-month period; each such authorization not to exceed a maximum of 10 visits or a period of 90 days, whichever occurs first. Reimbursement as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (California Physicians' Service).</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. As prescribed by a physician and furnished by a home health agency. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to or affects the disability which required such inpatient care (limitation not applicable when service is available to patient as a Medicare benefit). Prior authorization by local Medi-Cal consultant required for home health agency visits in excess of 10 (combined total for nursing and other types of services) in a 6-month period (authorization not required for services available to patient as a Medicare benefit). Reimbursement of home health agency on basis of reasonable cost (average cost per visit by discipline, based on submitted cost statement); of independent RN or LPN, as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (for home health agency claims, Hospital Service of California <i>or</i> Hospital Service of Southern California; for independent RN or LPN, California Physicians' Service).</p> <p>(b) Services of home health aide. Provided. As prescribed by a physician and furnished by a home health agency. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to or affects the disability which required such inpatient care (limitation not applicable when service is available to patient as a Medicare benefit). Prior authorization by local Medi-Cal consultant required for home health agency visits in excess of 10 (combined total for nursing and other types of service) in a 6-month period (authorization not required for services available to patient as a Medicare benefit). Reimbursement on basis of reasonable cost (average cost per visit by discipline, based on submitted cost statement). Claims processed and paid by fiscal agent (Hospital Service of California <i>or</i> Hospital Service of Southern California).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. As prescribed or ordered by a physician. No limitation on items furnished to categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when item is related to or affects the disability which required such inpatient care (limitation not applicable when items are available to patient as a Medicare benefit). Prior authorization by local Medi-Cal consultant required for items not listed in Medi-Cal formulary and for purchase, rental, repair, or maintenance of items when cost is in excess of \$50 (authorization not required when items are available to patient as a Medicare benefit). Reimbursement on basis of cost (according to Red Book or Blue Book) plus 50%; payment not to exceed usual charge to general public. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Provided. As ordered by attending physician. Limited to hospital inpatients; not provided for patients in skilled nursing home. No other limitations. Prior authorization by local Medi-Cal consultant required for service extending beyond 5 days (15 shifts). Reimbursement as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. For medically needy, only during 90-day period following discharge from an inpatient institution when service is related to the disability which required such inpatient care. Prior authorization required for specified services. Reimbursement of OEO clinics on basis of reasonable cost; of charitable free-standing clinics on basis of administrative overhead cost only, on a per visit basis. Claims processed and paid by fiscal agent (Hospital Service of California <i>or</i> Hospital Service of Southern California).</p>
<b>11. Dental Services</b>	<p>Provided. Including orthodontia. No limitation on services for categorically needy. Provided for medically needy only during 90-day period following discharge from an inpatient institution when service is related to or affects the disability which required such inpatient care. No requirements for prior authorization for emergency dental services for relief of pain, elimination of acute infection, or denture repair or adjustment. Prior authorization by local Medi-Cal consultant required in all non-emergency cases where cost exceeds \$35. No payment to dentist who provided denture for adjustment made within first year following provision of the denture. Reimbursement as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (California Physicians' Service).</p>

**B. Medical and Remedial Care and Services (Continued)****12. Physical Therapy and Related Services****a. Physical Therapy**

Provided. On physician's written prescription. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to or affects disability which required such inpatient care (limitation not applicable to services available to patient as a Medicare benefit). No requirements for prior authorization for services furnished to outpatients of rehabilitation centers or hospitals. Prior authorization by local Medi-Cal consultant required for more than 6 visits by a licensed private-practicing therapist in a 6-month period, or more than 10 visits by a home health agency (combined total for therapy, nursing, and other services) in a 6-month period. Reimbursement of home health agency on basis of reasonable cost; of private-practicing therapist as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (for claims from home health agencies, hospitals, clinics, and centers, Hospital Service of California or Hospital Service of Southern California; for private-practicing therapists' claims, California Physicians' Service).

**b. Occupational Therapy**

Provided. On physician's written prescription. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to or affects disability which required such inpatient care (limitation not applicable to services available to patients as a Medicare benefit). No requirements for prior authorization for services furnished to outpatients of rehabilitation centers or hospitals. Prior authorization by local Medi-Cal consultant required for more than 6 visits by a licensed private-practicing therapist in a 6-month period, or more than 10 visits by a home health agency (combined total for therapy, nursing, and other services) in a 6-month period. Reimbursement of home health agency on basis of reasonable cost; of private-practicing therapists as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (for claims from home health agencies, hospitals, clinics, and centers, Hospital Service of California or Hospital Service of Southern California; for private-practicing therapists' claims, California Physicians' Service).

**c. Speech Therapy**

Provided. On physician's written prescription. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to or affects disability which required such inpatient care (limitation not applicable when services are available to patient as a Medicare benefit). No requirements for prior authorization for services furnished to outpatients of rehabilitation centers, hospitals, or speech and hearing clinics. Prior authorization by local Medi-Cal consultant required for more than 6 visits by a licensed private-practicing therapist in a 6-month period, or more than 10 visits by a home health agency (combined total for therapy, nursing, and other services) in a 6-month period. Reimbursement of home health agency on basis of reasonable cost; of private-practicing therapist as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (for claims from home health agencies, hospitals, clinics, and centers, Hospital Service of California or Hospital Service of Southern California; for private-practicing therapists' claims, California Physicians' Service).

**d. Audiology**

Provided. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to or affects disability which required such inpatient care. No requirements for prior authorization for services furnished to outpatients of rehabilitation centers, speech and hearing clinics, or hospitals. Prior authorization by local Medi-Cal consultant required for more than 6 visits in a 6-month period. Reimbursement of private-practicing therapist as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (for institutions and clinics, Hospital Service of California or Hospital Service of Southern California; for private-practicing audiologist, California Physicians' Service).

**13. Prescribed Drugs**

Provided. Legend and non-legend drugs. Unlimited for categorically needy. Provided for medically needy only during 90-day period following discharge from an inpatient institution and only when related to condition for which patient was institutionalized. Prior authorization by local Medi-Cal consultant required for all drugs not listed in Medi-Cal formulary; approval granted only if required by patient's condition or if use results in less expensive treatment. Reimbursement of legend drugs on basis of acquisition cost plus \$2.30, or price charged to general public, whichever is lower; of non-legend items on basis of cost plus 50%. Claims processed and paid by fiscal agent (California Physicians' Service).



**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>	<p><b>a. Eyeglasses</b></p> <p>Provided. No limitations for categorically needy. Provided for medically needy only during 90-day period following discharge from an inpatient institution and only when related to condition for which patient was institutionalized. Prior authorization by local Medi-Cal consultant required for all services or appliances (other than replacement of broken eyeglass lenses) costing more than \$6. Reimbursement on basis of State Department of Finance Schedule of Maximum Allowances (by procedure code number). Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>b. Hearing Aids</b>	<p>Provided. On prescription by an otolaryngologist (or by physician, if services of an otolaryngologist are unavailable) after audiological evaluation by certified audiologist, otolaryngologist, or physician. Unlimited for categorically needy. Provided for medically needy only during 90-day period following discharge from an inpatient institution and only when related to condition for which patient was institutionalized. Prior authorization by local Medi-Cal consultant required for all hearing aids and for all repairs costing more than \$50 per repair service. Reimbursement on basis of State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>c. Dentures</b>	<p>Provided. No limitation on dentures for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when item is related to or affects the disability which required such inpatient care. No other limitations. Prior authorization by local Medi-Cal consultant required when cost exceeds \$35. Reimbursement as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>d. Other Prosthetic Devices</b>	<p>Provided. As prescribed by physician. All prosthetic and orthotic appliances necessary for restoration of bodily function or replacement of body part. Including custom-made orthopedic shoes. No limitations for categorically needy. Provided for medically needy only within 90-day period following institutional care when item is related to or affects the disability which required such inpatient care (limitation not applicable when items are available to patient as a Medicare benefit). Prior authorization by local Medi-Cal consultant required for items not listed in Schedule of Maximum Allowances or if cost exceeds listed maximum, and for any repairs costing over \$50. Reimbursement as charged, not to exceed State Department of Finance Schedule of Maximum Allowances. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>15. Family Planning Services</b>	<p>Provided, but not as a separately identified service. Drugs, supplies, and appliances are included. No requirements for prior authorization. Basis of reimbursement variable according to provider utilized. Claims processed and paid by fiscal agent (California Physicians' Service).</p>
<b>16. Services of Christian Science Nurses</b>	<p>Not provided.</p>
<b>17. Care and Services in Christian Science Sanatoria</b>	<p>Provided. No limitations, but service must be ordered by attending Christian Science practitioner. Authorization by local Medi-Cal consultant required (except for Medicare-covered period of stay); request must be submitted and received within 10 days following date of admission. Initial authorization may be granted up to end of second month following month of admission; subsequent reauthorizations must be obtained at least every 3 months. Reimbursement on basis of maximum per diem rate not to exceed \$14. Claims processed and paid by fiscal agent (Hospital Service of California or Hospital Service of Southern California).</p>
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	<p>Provided. For period of time necessary until patient can safely be removed to a certified facility. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Hospital Service of California or Hospital Service of Southern California).</p>
<b>19. Personal Care Services In Patient's Home</b>	<p>Not provided.</p>



### B. Medical and Remedial Care and Services (Continued)

<b>20. Other Diagnostic, Screening, Preventive and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. When patient is unable to use ordinary transportation and ambulance is necessary to obtain treatment covered by the program. No limitation on service for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to disability which required such inpatient care (limitation not applicable to services available to patient as a Medicare benefit). Prior authorization by local Medi-Cal consultant required (except where service is available as a Medicare benefit) for all non-emergency transportation exceeding distance of 25 miles one way. Reimbursement on basis of State Schedule of Maximum Allowances (by procedure code number). Claims processed and paid by fiscal agent (California Physicians' Service).
<b>b. Other</b>	<p>Provided. By bus, taxi, railway, or other appropriate means. Including meals and lodging enroute, and services of an attendant when necessary. No limitation on services for categorically needy. Provided for medically needy only within 90-day period following institutional inpatient care when service is related to disability which required such inpatient care. Prior authorization by local Medi-Cal consultant required for all non-emergency transportation exceeding distance of 25 miles one way. Claims processed and paid by fiscal agent (California Physicians' Service).</p> <p>[Ed. note: Prior to publication, transportation by means other than ambulance was deleted from State's Scope of Services, April 1970.]</p>

### C. Eligibility for Medical Assistance

<b>1. Date of Entitlement</b>	<p>Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month of application, provided all conditions of eligibility were met in the month in which services were rendered. On an emergency basis only, retroactive eligibility is permissible up to 3 months prior to month of application.</p>
<b>2. Conditions of Eligibility (By Age Groups)</b>	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p>
<b>a. Under Age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p>
	<p>(2) Child in foster home or private institution for whom a public agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</p>
	<p>(3) Children in the State's Aid to Adoption of Children Program.</p>
	<p>(4) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p>
	<p>(5) Person who is blind (State definition) and age 16 or older.</p>
	<p>(6) Person who is permanently and totally disabled (State definition) and age 18 or older.</p>
<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
<b>c. Age 65 or older</b>	<p>(1) Individual who has attained age 65.</p>

**C. Eligibility for Medical Assistance (Continued)**

<p><b>3. Coverage of the Categorically Needy</b></p> <p><b>a. FFP Claimed in Medical and Administrative Costs</b></p> <p><b>b. FFP Claimed in Administrative Costs Only</b></p>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(7) All children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part.</p> <p>(8) Children in the State's Aid to Adoption of Children Program.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(1) Federally ineligible AFDC-Unemployed Parent cases.</p> <p>(2) Recipients of the State and county financed program of Aid to the Potentially Self-Supporting Blind.</p>
<p><b>4. Coverage of the Medically Needy</b></p>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Items C.3.a. and b., above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.</p>
<p><b>5. Financial Criteria</b></p> <p><b>a. For Categorically Needy Persons</b></p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>



**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p>(1) <i>Income</i></p> <p>Annual income which may be retained for basic maintenance needs: \$1944 for one person, \$2400 for family of 2, \$2796 for 3, \$3600 for 4, \$4164 for 5, and \$264 for each additional person.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$15 a month for personal expenses. If patient is maintaining a home which there is a reasonable expectation he will return to within six months, maintenance allowance is allowed not to exceed \$45 per month when home is shared or \$63 for single individual who lives alone. Additional income may be applied to maintenance needs of dependents up to \$1944 a year for one dependent, \$2400 for 2 dependents, and higher amounts for additional dependents (according to progression stated in preceding paragraph).</p> <p>(2) <i>Resources</i></p> <p>May retain home regardless of value.</p> <p>Personal effects, household furnishings, and one automobile needed for transportation are exempt.</p> <p>Other real and personal property (including market value of non-home real property and cash value of life insurance), both income-producing and non-income-producing, may be retained up to a total value of \$1500 for one person, or \$3000 for a family of two or more.</p> <p>Resources in excess of these amounts do not render an individual ineligible but are considered a component of his share of costs to the following extent: 6% of market value up to \$20,000 excess, and total market value above \$20,000 excess.</p> <p>[Ed. note: Data as of 1/1/70; substantive changes were made later in 1970.]</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>A "Medi-Cal Identification Card" is issued by the county department of welfare. The names of all eligible persons in the case are listed on the card with a "person number" assigned as identification. The card is carbon-interleaved with five copies. A copy of the card is to be attached to each claim submitted to the fiscal intermediaries. There is space on the card to identify "the bearer's share of cost, if any" and spaces for the recipient to list the kind of medical services received, the dates, and the costs which may then be considered against the amount of the "bearer's share". All copies of the form are signed by the person in whose name the card is issued.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Department of Health Care Services is the "single State agency" and the "medical assistance unit" which is directly responsible for the administration of the program. The Director (medical administration) is assisted by a physician as head of a Division of Program and Planning and a Chief of the Field Services Bureau. Each of the 12 districts is staffed by medical, dental, and social service consultants; and the 2 larger districts have consultants also in the fields of optometry and pharmacy.</p>
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of medical aspects of Statewide operations is accomplished through 12 District offices, grouped into 3 Regions, under direction of the Field Services Bureau of the Department of Health Care Services. Staff of the Bureau, or county Medi-Cal consultant staff under the guidance of the Bureau, provide a program control by determining the medical necessity for those services which require prior authorization and by determining the appropriate level of care to meet the medical needs of the recipient.</p> <p>Supervision of Statewide aspects of eligibility determination and related aspects of the program is through the field staff of the State Department of Social Welfare.</p>



**D. Administration and Management (Continued)**

<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Health Review and Program Council. It is composed of 11 members appointed by the Governor and 5 ex officio members (Director of Health Care Services, Director of Social Welfare, Director of Public Health, Director of Rehabilitation, and Director of Mental Hygiene). Authority for the Council is statutory.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Health Care Services processes and pays claims for services in institutions for mental diseases, both inpatient hospital care and skilled nursing home care. For claims from providers of all other kinds of care encompassed in the program, the State has contracts with three fiscal agents for specified services, as reported in Item b. below.
<b>b. Fiscal Agents</b>	State agency has contracts with Hospital Service of California (Blue Cross) and with Hospital Service of Southern California (Blue Cross) to process and pay claims from general hospitals, hospitals for tuberculosis, skilled nursing homes, home health agencies, clinics, and Christian Science sanatoria.  Claims from providers of all other kinds of services (except institutions for mental diseases, see item a. above) are processed and paid by the California Physicians' Service (Blue Shield) under contract as fiscal agent.
<b>c. Prepaid Capitation Arrangements</b>	Heavy emphasis has been placed on studying prepayment/capitation type programs involving different types of providers and health service organizations as the Department has developed pilot projects and Demonstration Studies to explore innovative and efficient methods of providing health care services. A study is being conducted in a selected area to provide incentives to reduce costs through maximizing the efficiency of hospitals.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for California as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.00.
<b>2. State/Local Participation</b>	For the non-Federal share of the costs of both medical assistance and administration of the program, State and local funds are used. The county share is based on actual costs in fiscal year 1964-65, increased in subsequent years proportionately to population increases. For the 1969 fiscal year, the county share was 22% and the State share was 78% of the non-Federal share of the costs.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually for title XIX and county indigent medical care program. Any unobligated balance reverts to the General Fund at the end of the fiscal year.
<b>4. Deficit Financing</b>	If additional funds are needed to meet the State's share of medical vendor payments before the next appropriation period, the program must be curtailed or additional funds secured by emergency action of the Governor and the State Legislature.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Social Services

January 1, 1970

COLORADO

**A. General Information**

<b>1. Legal Base</b>	Chapter 119 and Chapter 101, Colorado Revised Statutes, 1963, as amended; article XXIV of the Colorado Constitution; and Chapter 63, 1968 Session Laws of Colorado.
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1969. Original plan approved by the Federal agency on December 27, 1968.
<b>3. Administrative Responsibility</b>	The Department of Social Services serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of 63 county departments of public welfare.
<b>4. Historical Background</b>	<p>Vendor payments for medical services under the public assistance programs began for AB, APTD, and AFDC in September 1957 and for OAA in February 1958. The content of medical services and the method of payment varied among the categories: For OAA, hospitalization and physicians' services were paid for through Blue Cross-Blue Shield organizations as fiscal agents, prescribed drugs for patients in nursing homes were paid for directly to the pharmacists, and nursing home care was supplied through a combination of the money payment to the recipient and a vendor payment to the nursing home for the remainder of the allowable rate. For AB and AFDC children, there was a group pre-payment insurance contract with Colorado Hospital Service and Colorado Medical Service for a specified content of care (Comprehensive Blue Cross and Standard Blue Shield). Colorado was the first State to use a group pre-payment contract with a private insurance company for Statewide coverage of recipients of aid under one of the Federal-State public assistance programs. For APTD, vendor payments were made only for prescribed drugs, directly to the pharmacist. Nursing home care was provided for AB and APTD through the money payment to the recipient. Some other minor services were provided in all categories through vendor payments. This pattern continued, with the addition of AFDC mothers to the group-insurance coverage in 1962 and vendor payments for short-term nursing home care for AB and APTD in July 1966.</p> <p>During the period July 1, 1964, through December 1968, the State maintained a program of Medical Assistance for the Aged (MAA), a Federal-State program for persons age 65 or older who were not recipients of public assistance but who met certain prescribed conditions of financial and medical need. The scope of services was essentially the same as for OAA except that only short-term nursing home care was provided under OAA and long-term nursing home care for persons over the age of 65 was provided through transfer of eligible persons to the MAA program with special provision to meet personal-care needs of persons who had no source of income. There was some adjustment of services under both OAA and MAA programs when the title XVIII Medicare services began in 1966.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available under the program is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.c. and B.4.c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Item B.8.(b))</p> <p>Certain services provided for all recipients are made available on a more liberal basis to individuals covered by the State's buy-in agreement. (Items B.2., B.3., B.6., B.7.a., B.8.(c), and B.12.a., b., and c.)</p>



**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	<p><b>a. In General Hospitals</b></p> <p>Provided. No limitations. Prior authorization by State office required for extensions beyond 18 days in a benefit period (new benefit period begins after time lapse of 60 consecutive days between periods of inpatient hospitalization). Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p>
<p><b>b. In Institutions For Tuberculosis</b></p>	<p>Not provided.</p> <p>[Colorado has no institutions which are separately licensed for the treatment of tuberculosis. Long-term care of needy tubercular patients is provided through a State-financed Tuberculosis Assistance Program, which is administered by the Division of Tuberculosis of the State Department of Social Services.]</p>
<p><b>c. In Institutions for Mental Diseases</b></p>	<p>Provided. Limited to persons age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Social Services.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. Unlimited for persons age 65 or older covered by State's buy-in agreement. For others, unlimited except that cost of diagnostic laboratory and X-ray services may not exceed \$100 per calendar year. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. Through physician's office or by an independent laboratory. Unlimited services for persons age 65 or older covered by State's buy-in agreement. For others, unlimited except that, in combination with such services received as a hospital outpatient, cost of diagnostic laboratory and X-ray services may not exceed \$200 a year. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p>
<p><b>4. Skilled Nursing Home Services</b></p> <p><b>a. General</b></p>	<p>Provided. For persons of all ages. No limitations. No requirements for prior authorization. Reimbursement on basis of rate individually determined by State Department for each nursing home (computed on basis of audited costs or \$10 per day, whichever is less, plus a 3% allowance for fluctuating costs of proprietary, non-profit, and tax supported homes, plus a reasonable profit of 70¢ per day for proprietary homes or 52¢ per day for non-profit and tax-supported homes). Claims processed and paid by State Department of Social Services.</p>
<p><b>b. In Institutions for Tuberculosis</b></p>	<p>Not provided.</p>
<p><b>c. In Institutions for Mental Diseases</b></p>	<p>Provided. Limited to persons age 65 or older in public or private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Social Services.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. For persons age 65 or older covered by the State's buy-in agreement, unlimited services, with no requirements for prior authorization. For other eligible persons, unlimited surgical and emergency care wherever provided; services to a hospital inpatient, limited to those provided on days for which hospital charges are payable; for other services, prior authorization from State office required for visits beyond established limit of 12 medical visits per calendar year plus one visit per month to patients in skilled nursing homes. Reimbursement on basis of usual and customary charges not to exceed fee structure (maximum allowable payment) established by State agency (application of conversion factor to unit values set forth in 1968 edition of Colorado Medical Society's "Relative Value Study"). Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>	<p>Provided. For persons age 65 or older covered by State's buy-in agreement, all such services provided as benefits under Medicare (Part B). For others, limited to non-routine corrective surgical procedures. Professional agreement between the podiatrist and the attending physician (knowledge and consent of attending physician) required. No requirements for prior authorization. Reimbursement on basis of usual and customary charges not to exceed fee structure (maximum allowable payment) established by State agency (application of conversion factor to unit values set forth in 1968 edition of Colorado Medical Society's "Relative Value Study"). Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p>
<b>b. Optometrists</b>	<p>Not provided.</p>
<b>c. Chiropractors</b>	<p>Not provided.</p>
<b>d. Other</b>	<p>Not provided.</p>
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided if furnished by home health agency. Limited to 100 visits per year (in combination with all other home health agency visits). No requirements for prior authorization. Reimbursement on basis of reasonable charges (as paid by Social Security Administration for Medicare benefits). Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p> <p>(b) Services of Home Health aide. Provided if furnished by home health agency. Limited to persons age 65 or older covered by State's buy-in agreement. Limited to 100 visits per year (in combination with all other home health agency visits). No requirements for prior authorization. Reimbursement on basis of reasonable charges (as paid by Social Security Administration for Medicare benefits). Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. Medical supplies limited to those furnished by home health agency. No other limitations. For persons not covered by State's buy-in agreement, prior authorization by State office required for purchase or rental of wheel chairs, walkers, and hospital beds prescribed by physician. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Not provided.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>11. Dental Services</b>	<p>Not provided.</p> <p>[Exception: Payment made for surgery related to the jaw or structures contiguous to the jaw, and for reduction of fractures of the jaw or any facial bone.]</p>
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	<p>Provided. Limited to persons age 65 or older covered by State's buy-in agreement. To the extent provided as a benefit under Medicare (Part B). No requirements for prior authorization. Reimbursement on basis of reasonable charges (as paid by Social Security Administration for Medicare benefits). Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p>
<b>b. Occupational Therapy</b>	<p>Provided. Limited to persons age 65 or older covered by the State's buy-in agreement, and to services furnished by a home health agency. 100 visits per year (in combination with all other home health agency visits). No requirements for prior authorization. Reimbursement on basis of reasonable charges (as paid by Social Security Administration for Medicare benefits). Claims processed and paid by fiscal agent (Colorado Hospital Services and Colorado Medical Service, Inc.).</p>
<b>c. Speech Therapy</b>	<p>Provided. Limited to persons age 65 or older covered by State's buy-in agreement, and to services furnished by a home health agency. 100 visits per year (in combination with all other home health agency visits). No requirements for prior authorization. Reimbursement on basis of reasonable charges (as paid by Social Security Administration for Medicare benefits). Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p>
<b>d. Audiology</b>	<p>Not provided.</p>
<b>13. Prescribed Drugs</b>	<p>Provided. Limited to legend drugs, insulin, and such medications and devices as are prescribed in family planning. No other limitations. Prior authorization by the State Department required for restricted drugs, which includes all prescribed legend vitamins and anti-obesity drugs. Reimbursement to pharmacists on basis of acquisition cost plus dispensing fee of \$1.50 per prescription; payment not to exceed vendor's usual charge to general public. Dispensing physician who applies to participate as a dispensing pharmacist and agrees to keep all necessary records will receive a professional fee of \$0.80 per prescription. Claims processed and paid by State Department of Social Services.</p>
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	<p>Not provided.</p> <p>[Exception: First pair of corrective lenses (spectacle or contact) required following eye surgery is provided.]</p>
<b>b. Hearing Aids</b>	<p>Not provided.</p>
<b>c. Dentures</b>	<p>Not provided.</p>
<b>d. Other Prosthetic Devices</b>	<p>Provided. Limited to devices which artificially replace all or part of an internal body organ and which are surgically implanted on an inpatient basis. No limitations. No requirements for prior authorization. Reimbursement on basis of the maximum allowable payment, which shall be the lowest of (1) the individual supplier's usual and customary charge, (2) the area prevailing rate, or (3) the Statewide prevailing rate as developed and approved by the State agency. Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>15. Family Planning Services</b>	Provided. Consisting of physicians' services, drugs, supplies, and devices. Physician's services limited to medical visit(s) necessary to determine medications or devices to be used. No other limitations. No requirements for prior authorization. Reimbursement to physicians on basis of reasonable charges; to pharmacies on basis of acquisition cost plus \$1.50 dispensing fee per prescription, but not in excess of usual charges to general public. Claims for physicians' services processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.); for pharmaceuticals, by State Department of Social Services.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. No limitations, but patient must be moved to a qualified hospital as soon as medically safe. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. By air ambulance, emergency ambulance service, ambulance, and wheel-chair car service, upon certification by attending physician that patient's condition precludes use of other methods of transportation. Limited to transportation between (any combination of) hospital, nursing home, and patient's home. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by fiscal agent (Colorado Hospital Service and Colorado Medical Service, Inc.).
<b>b. Other</b>	Provided. Public transportation, when origin or destination is hospital, nursing home, or independent laboratory, and when demonstrated by attending physician that patient himself can not reasonably or prudently be expected to provide transportation. Prior authorization by State office required. Reimbursement on the basis of agreement between the county department of public welfare and the public transportation firm. (Payment is made by the county department from its general assistance funds in the amount of \$1.00 or more; receipt is presented to State agency for reimbursement.) Claims processed and paid by State Department of Social Services.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as seven days prior to date of application, provided all conditions of eligibility were met in the month in which services were rendered.
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**C. Eligibility for Medical Assistance (Continued)**

<p><b>2. Conditions of Eligibility (By Age Groups)</b></p> <p><b>a. Under Age 21</b></p> <p><b>b. Age 21 to 64</b></p> <p><b>c. Age 65 or older</b></p>	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p> <p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Child in foster home or private institution for whom a public agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</p> <p>(4) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(5) Person who is blind (State definition).</p> <p>(6) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child of parental support or care is living. (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is premanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or AFDC.</p> <p>(1) Individual who has attained age 65.</p>
<p><b>3. Coverage of the Categorically Needy</b></p> <p><b>a. FFP Claimed in Medical and Administrative Costs</b></p> <p><b>b. FFP Claimed in Adminisitrative Costs Only</b></p>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(5) All children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part.</p> <p>(6) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
<p><b>4. Coverage of the Medically Needy</b></p>	<p>Not included.</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>5. Financial Criteria</b>  <b>a. For Categorically Needy Persons</b>  <b>b. For Medically Needy Persons</b>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>Not included.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>Medicaid Identification Cards are issued monthly or quarterly by the Department of Social Services. A card is issued in the name of an adult member of each family certified as eligible by the county welfare office, showing dates of issuance and expiration, and listing the names and birth dates of all eligible members of the family. Where certification is for an individual rather than a family, a Medicaid Identification Card is issued quarterly, showing name of recipient and dates of issuance and expiration; this card, however, indicates eligibility only through the month of issuance; for the remainder of the quarter, vendors are on notice to contact the county welfare office for verification of continuing eligibility. Where eligibility of an individual or family does not begin on the first day of the month, a temporary Medicaid Identification Card is issued by the local welfare office.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Medical Care Unit (medical assistance unit) is headed by a Director (M.D.) who is responsible to the Director of the Division of Public Welfare. There is a full-time staff of Deputy Director (administrator) Director of Pharmacy Services, Director of Mental Health Services, Director of Nursing Home Services, 3 principal social workers, and a special investigator for pharmaceutical services. In addition there are consulting physicians in the fields of disability, ophthalmology, psychiatry, and tuberculosis. All staff are appropriately qualified in the respective disciplines.</p>
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of Statewide operations is accomplished through six full-time and four part-time supervisory staff responsible to the Medical Services Section and one full-time and two part-time consultative staff. They are supplemented by the agency's general field staff of 16 supervisory positions and 2 consultative ones.</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Medical Advisory Council. It is composed of 15 members appointed by the Governor and three ex officio members: Executive Director, Colorado State Department of Social Services; Director, Division of Public Welfare; Executive Director, Colorado State Department of Public Health. Authority for the Council is statutory.</p>
<b>4. Buy-In Agreement</b>	<p>State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients who are eligible for benefits under title XVIII of the Social Security Act.</p>
<b>5. Claims Payment Process</b>  <b>a. State and Local Agencies</b>  <b>b. Fiscal Agents</b>	<p>The State Department of Social Services processes claims and makes payment for services provided to persons age 65 or older who are in public or private institutions for mental diseases receiving either inpatient hospital care or skilled nursing home care; for skilled nursing home care services for persons of all ages; for prescribed drugs, including those prescribed in relation to Family Planning services; and for transportation by public means, other than ambulance, necessary to receive medical care. All other services are handled by the fiscal agents.</p> <p>State has contract with Colorado Hospital Service (Blue Cross) and Colorado Medical Service, Inc. (Blue Shield) for processing and payment of claims from providers of all the kinds of care and services covered by the title XIX plan except those listed in sub-item a., above.</p>

**D. Administration and Management (Continued)**

<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Colorado as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 56.24.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of medical assistance under the plan and State and local funds are used for the non-Federal share of costs of administration: 80% State participation and 20% county participation.
<b>3. Source of State Funds</b>	State's share of program costs is derived from revenues available to the State agency, special appropriation from such funds for nursing home care, and appropriation from General Fund for State share of costs of administration. Unobligated balance reverts to the General Fund at the end of each fiscal year.
<b>4. Deficit Financing</b>	If additional funds are needed before the next appropriation period, they may be secured by action of the State's Legislative Joint Budget Committee.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Welfare Department

January 1, 1970

CONNECTICUT

**A. General Information**

<b>1. Legal Base</b>	General Statutes of Connecticut, 1965 Supplement, Section 17 - 12b, Subsection (a).
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on September 2, 1966.
<b>3. Administrative Responsibility</b>	The State Welfare Department is the single State agency with responsibility for administering the program through a system of district and sub-district offices on a Statewide basis.
<b>4. Historical Background</b>	Beginning October 1, 1950, with the full implementation of existing law, vendor payments were made for all "necessary and reasonable" medical care and services provided to public assistance recipients of OAA, AB, and AFDC. When the APTD program began January 1, 1954, recipients under that program were added. In addition, under legislation enacted in 1961, effective April 15, 1962, a program of Medical Assistance for the Aged was instituted for persons age 65 or over who were not recipients of public assistance but who met certain prescribed conditions of financial and medical need. These services continued until the beginning of the title XIX program.
<b>5. Scope of Coverage</b>	Program provides for coverage of both categorically needy and medically needy persons. (See Items C.3. and C.4., below.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical Assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for mental diseases are provided only for patients who are 65 years of age or older. (Item B. 4.c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. No limitations. No requirements as to prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Welfare Department.
<b>b. In Institutions for Tuberculosis</b>	Not provided. [State has no separately established institutions for tuberculosis.]
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older who are patients in State-operated institutions. No requirements as to prior authorization. Reimbursement at State per diem rate. Claims processed and paid by State Welfare Department.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. Prior authorization required for special services beyond clinic visit. Reimbursement on reasonable cost basis. Claims processed and paid by State Welfare Department, except for coinsurance and deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).
<b>3. Other Laboratory and X-ray Services</b>	Provided. In licensed and accredited independent laboratories which are registered with the State Health Department. No limitations. No requirements as to prior authorization. Reimbursement according to fee schedule based on reasonable costs. Claims processed and paid by State Welfare Department, except for coinsurance and deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).

**B. Medical and Remedial Care and Services (Continued)**

<p><b>4. Skilled Nursing Home Services</b></p> <p><b>a. General</b></p> <p><b>b. In Institutions for Tuberculosis</b></p> <p><b>c. In Institutions for Mental Diseases</b></p>	<p>Provided. For persons of all ages. No limitations. No requirements for prior authorization other than medical review to determine level of care. Reimbursement of fees based on reasonable cost. Claims processed and paid by State Department, except for deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p> <p>Not provided. [State has no separately established institutions for tuberculosis.]</p> <p>Provided. Limited to persons age 65 or older who are patients in State-operated institutions. No requirements for prior authorization. Reimbursement at State per diem rate. Claims processed and paid by State Welfare Department, except for deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p>
<p><b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b></p>	<p>Provided. In neighborhood health centers through Head Start programs and city health department programs.</p>
<p><b>6. Physicians' Services (M.D. and D.O.)</b></p>	<p>Provided. No limitations. Prior authorization required for home or office visits of general practitioners exceeding 5 per month in acute illness or one per month in chronic illness; also required for specialists' services beyond initial visit. Reimbursement on basis of fee schedule. Physicians' services provided in hospital clinic or emergency room are not reimbursable direct to physician but are included in hospital charge. Claims processed and paid by State Welfare Department, except for coinsurance and deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p>
<p><b>7. Services of Licensed Practitioners</b></p> <p><b>a. Podiatrists</b></p> <p><b>b. Optometrists</b></p> <p><b>c. Chiropractors</b></p> <p><b>d. Other</b></p>	<p>Provided. Unlimited, except no reimbursement for X-rays or surgery. No requirements for prior authorization. Reimbursement on basis of fee schedule based on reasonable charges. Claims processed and paid by State Welfare Department, except for coinsurance and deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p> <p>Provided. Unlimited except for exclusion of tonometry. Eyeglasses limited to one pair, except in special circumstances. Prior authorization required for contact lenses, visual training, visual motor or perceptual evaluation, prescription sunglasses, replacement of complete glasses without prescription change. Reimbursement on basis of fee schedule based on reasonable charges; except eyeglasses, for which reimbursement is based on wholesale cost. Claims processed and paid by State Welfare Department.</p> <p>Provided. Unlimited except no reimbursement for X-rays. Prior authorization required for home or office visits exceeding 5 per month in acute illness or one per month in chronic illness. Reimbursement on basis of fee schedule based on reasonable charges. Claims processed and paid by State Welfare Department.</p> <p>Provided. Services of naturopaths. No limitations. Prior authorization required for home or office visits exceeding 5 per month in acute illness or one per month in chronic illness. Reimbursement on basis of fee schedule based on reasonable charges. Claims processed and paid by State Welfare Department.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided if furnished by a home health agency or a visiting nurse association. Unlimited. During any one illness, physician's order required after first 2 visits, and prior authorization required after first 5 visits. Reimbursement of home health agency on basis of cost; of visiting nurse association on basis of fee schedule. Claims processed and paid by State Welfare Department, except for coinsurance and deductible under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p> <p>(b) Services of home health aide. Provided for all recipients. No requirements for prior authorization up to 12 hours per month. Claims processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations. Prior authorization required if over \$10. Reimbursement on basis of fee schedule. Claims processed and paid by State Welfare Department, except for coinsurance and deductible under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Provided. Limited to hospital inpatients. Prior authorization required after 72 hours. Reimbursement at "going rate". Claims processed and paid by State Welfare Department.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. No limitations. Prior authorization required for certain procedures. Claims processed and paid by State Welfare Department, except for coinsurance and deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p>
<b>11. Dental Services</b>	<p>Provided. All general dental services, and dentures. Orthodontia and periodontia excluded. Prior authorization required. Reimbursement on basis of fee schedule based on reasonable charges. Claims processed and paid by State Welfare Department.</p>
<b>12. Physical Therapy and Related Services</b>	<p><b>a. Physical Therapy</b></p> <p>Provided. Only in clinic or designated rehabilitation centers or centers for mentally retarded. No other limitations. Prior authorization required. Reimbursement based on fee schedule. Claims processed and paid by State Welfare Department, except for coinsurance and deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p> <p><b>b. Occupational Therapy</b></p> <p>Provided. Only in clinic or designated rehabilitation centers or centers for mentally retarded. No other limitations. Prior authorization required. Reimbursement based on fee schedule. Claims processed and paid by State Welfare Department, except for coinsurance and deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p> <p><b>c. Speech Therapy</b></p> <p>Provided. Only in clinic or designated rehabilitation centers or centers for mentally retarded. No other limitations. Prior authorization required. Reimbursement based on fee schedule. Claims processed and paid by State Welfare Department, except for coinsurance and deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).</p> <p><b>d. Audiology</b></p> <p>Provided. No limitations. Prior authorization required. Reimbursement of Doctor of Medicine based on fee schedule. Reimbursement of audiologist based on fee schedule/negotiated rate. Claims processed and paid by State Welfare Department.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs. For persons in nursing homes and rest homes with nursing supervision, provided through contract arrangement with pharmacy of low bid; for other persons, may be furnished by any licensed pharmacy. Prior authorization required for drugs costing more than \$10. Reimbursement on basis of cost plus 66-2/3%. Claims processed and paid by State Welfare Department.
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Provided. Limited to one pair, except in special circumstances. Prior authorization required for replacement of complete glasses without prescription change, contact lenses, and sunglasses. Reimbursement on basis of wholesale cost. Claims processed and paid by State Welfare Department.
b. Hearing Aids	Provided. Only after examination by otolaryngologist or audiologist. Prior authorization required. Reimbursement on basis of retail cost less 20%. Claims processed and paid by State Welfare Department.
c. Other Prosthetic Devices	Provided. Artificial limbs, braces, special shoes, abdominal and other supports. Prior authorization required. Reimbursement on basis of fee schedule based on reasonable charge. Claims processed and paid by State Welfare Department.
<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices. No limitations. No requirements for prior authorization. May be provided by physician or certified family planning clinic. Reimbursement on basis of fee schedule based on reasonable charge. Claims processed and paid by State Welfare Department.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. No limitations. Prior authorization required. Reimbursement on basis of cost. Claims processed and paid by State Welfare Department, except for coinsurance and deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).
<b>18. Emergency Hospital Services (in hospitals not qualified under Medicare)</b>	Not provided.  [All hospitals in Connecticut are certified under Medicare.]
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive and Rehabilitative Services</b>	Provided. No limitations, except that nothing experimental is provided. Prior authorization required. Reimbursement on basis of fee schedule based on reasonable cost. Claims processed and paid by State Welfare Department, except for coinsurance and deductibles under title XVIII (Medicare), which are processed and paid by fiscal agent (Connecticut General Life Insurance Company).
<b>21. Transportation</b>	
a. Ambulance	Provided. No limitations. Prior authorization required, except for emergencies. Reimbursement on basis of fee schedule based on reasonable charge. Claims processed and paid by State Welfare Department.
b. Other	Provided. Limited to chair car or other invalid carrier. No payment for transportation by common carrier or taxi. Prior authorization required. Reimbursement on basis of fee schedule based on reasonable charge. Claims processed and paid by State Welfare Department.

### C. Eligibility for Medical Assistance

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first of the month immediately preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	(1) Individual under age 21.
<b>b. Age 21 to 64</b>	<p>(1) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD or AFDC except for an eligibility condition or requirement that is prohibited in a program of medical assistance under title XIX.</p> <p>(3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD or AFDC.</p> <p>(5) Caretaker relatives (as specified in the State's AFDC plan) with whom dependent children described in Item C.3.a.(3), above, are living.</p> <p>(6) Individuals under age 21.</p> <p>(7) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD or AFDC programs but who would be eligible for such assistance if they left the facility.</p>
<b>b. FFP Claimed in Administrative Costs Only</b>	None.
<b>4. Coverage of the Medically Needy</b>	Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a., above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD, and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided for such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.



**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p>(1) <i>Income</i> Gross annual income (defined as income prior to deductions for taxes or any other items) which may be retained for basic maintenance needs: \$1900 for one person, \$2500 for 2 persons, \$3400 for 3 persons, \$4400 for 4 persons, plus \$600 for each additional dependent member of the family in the home.</p> <p>For a person in long-term care in a medical facility, net monthly income of \$5.50 (\$66 per year) may be retained for personal needs or, if married, \$192 (\$2304 per year) to cover both personal needs and needs of spouse living in the community.</p> <p>(2) <i>Resources</i> Real property used as a home, personal and household effects, and an automobile essential for transportation may be retained regardless of value. Other personal property may be retained up to a value of \$250 for one person, \$500 for 2 persons, plus \$100 for each additional dependent family member in the home. In addition, a person may have a prepaid funeral contract providing for burial in an amount not exceeding \$600, or U.S. Government Veteran's life insurance, or both.</p> <p>Resources in excess of these amounts disqualify applicant from receiving medical assistance under the program.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse and parents for children under age 21 and adult children who are blind or permanently and totally disabled.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>Both money payment and non-money payment recipients are issued a monthly medical identification card showing dates of eligibility and, in addition, receive a plastic embossed card (credit card type) with imprinted device for billing by providers.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Medical Services Unit (the medical assistance unit) is located in the Bureau of Staff Services of the State Welfare Department. The Medical Director of the Unit is responsible to the Chief of the Bureau of Staff Services who, in turn, is directly responsible to the Commissioner of the State Welfare Department. In addition to a full-time Director (M.D.), the professional staff of the Medical Services Unit includes the full-time services of the Chief, Medical Social Services Program, 3 medical social work consultants, 2 dental consultants, and one pharmacist consultant; also, on a part-time basis, an Assistant Medical Director (M.D.) and 2 physicians (Medical Review Administration). Services of a psychiatrist and of a pharmacist (staff member of the Division of Internal Audit) are available on a part-time basis.</p>
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of Statewide operations is accomplished through the activities of a general field staff consisting of 5 supervisory positions (social work). The part-time services of a medical consultant (M.D.) are available to each of the 8 district offices.</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Title XIX Advisory Committee. The Committee consists of 31 members appointed by the Commissioner of Welfare. There are no ex officio members. Selection of the chairman is made by vote of the membership. Authority for the Committee is administrative.</p>
<b>4. Buy-In Agreement</b>	<p>State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all persons age 65 or older receiving money payments under the State's OAA, AB, APTD, or AFDC programs who are eligible for services under both title XVIII of the Social Security Act and the State's title XIX program.</p>



**D. Administration and Management (Continued)**

<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Welfare Department processes and pays all vendor claims for services provided to eligible recipients with the exception of those handled by fiscal intermediary in connection with title XVIII coinsurance and deductibles (see Item D.5.b., below).
<b>b. Fiscal Agents</b>	Connecticut General Life Insurance Company serves as fiscal agent for the State Welfare Department. Company processes all claims for services rendered to aged recipients which are covered by title XVIII (except inpatient hospital care); determines whether coinsurance and deductible obligations have been met; if not, determines amount payable under State's system of reimbursement and makes direct payment to vendor.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Connecticut as promulgated by the Secretary for the period 7/1/69 to 6/30/71 is 50%.
<b>2. State/Local Participation</b>	State funds are used to finance 100% of the non-Federal share of costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs are derived from appropriations from State General Funds. Appropriations are made biennially; unobligated balance reverts at end of biennium.
<b>4. Deficit Financing</b>	When additional funds are needed to meet a deficit before the next appropriation period, a deficit appropriation is obtained from the Finance Advisory Committee which meets monthly. State Welfare Department operates on a completely open-end budget.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

DELAWARE

## A. General Information

1. Legal Base	Title 31, Section 502, Delaware Code, as amended June 1968.
2. Beginning Dates	Program went into operation on October 1, 1966. Original plan approved by the Federal agency on February 17, 1967.
3. Administrative Responsibility	<p>The Department of Public Welfare serves as the single State agency with responsibility for administering the program on a Statewide basis through its three county offices.</p> <p>The Commission for the Blind, as the separate State agency administering the Aid to the Blind program, has responsibility for certifying the eligibility of persons whose eligibility is related to blindness or the AB program.</p>
4. Historical Background	<p>Provisions for payment of costs of medical care with Federal financial participation as part of the public assistance programs were in effect for the Aid to the Blind program in July 1957. By 1962 the scope of services covered nursing home care, eye surgery, dentures and denture repair, and approved prosthetic appliances. Any other medical care needed was budgeted in the money payment, subject to the monthly maximum on the total money payment for subsistence.</p> <p>In 1962 the Legislature authorized vendor payments for medical care provided to recipients of OAA, effective November 1, 1962. The scope of services defined in the statute was broad, but the program began with inpatient hospital care and pharmaceutical services. Gradually, during 1963, other services were added (outpatient clinic, home health care by visiting nurse, physicians' services, dental services including dentures, podiatrists', optometrists' services and glasses, and chiropractors'). Nursing home care was provided through the money payment to the recipient. No provision was made for vendor payments in the APTD or the AFDC programs.</p> <p>In December 1964 the State began a Federal-State program of Medical Assistance for the Aged (for persons age 65 and older who were not recipients of public assistance but met certain criteria of financial and medical need). The defined scope of services was comprehensive, but the program was begun with inpatient and outpatient hospital services, home health care, services of visiting nurses, and prescribed drugs. No other services were added before the implementation of the Title XIX program.</p> <p>This Medicaid program also began with limited services (the five basic services as required by title XIX plus "legend drugs") authorized by legislation in 1966 and was expanded by legislation in 1968 to include "other health services and supplies. . . on recommendation of the Medical Advisory Committee".</p>
5. Scope of Coverage	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.) [Ed. Note: Prior to publication, coverage of "medically needy" persons was eliminated from the program, effective May 14, 1970.]
6. Differences in Scope of Services Provided	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B.7.a.; B.8.(c); B.14.d.; B.21.a.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
a. In General Hospitals	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).
b. In Institutions for Tuberculosis	Provided. Limited to persons age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).
c. In Institutions for Mental Diseases	Provided. Limited to persons age 65 or older in Delaware State Hospital. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).
<b>4. Skilled Nursing Home Services</b>	
a. General	Provided. Limited to persons age 21 or older. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).
b. In Institutions for Tuberculosis	Not provided.
c. In Institutions for Mental Diseases	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. Routine physical examinations and routine eye refractions excluded. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).
<b>7. Services of Licensed Practitioners</b>	
a. Podiatrists	Provided. Limited to persons age 65 or older covered by State's buy-in agreement, and to such services when available as benefits under Medicare. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).
b. Optometrists	Not provided.
c. Chiropractors	Not provided.
d. Other	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. As furnished by home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).</p> <p>(b) Services of home health aide. Provided. As furnished by home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. Limited to persons age 65 or older covered by State's buy-in agreement; consisting of rental or purchase of durable equipment and other items available as benefits under Medicare. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).</p>
<b>11. Dental Services</b>	<p>Not provided.</p>
<b>12. Physical Therapy and Related Services</b>	<p><b>a. Physical Therapy</b></p> <p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).</p> <p><b>b. Occupational Therapy</b></p> <p>Not provided.</p> <p><b>c. Speech Therapy</b></p> <p>Not provided.</p> <p><b>d. Audiology</b></p> <p>Not provided.</p>
<b>13. Prescribed Drugs</b>	<p>Provided. Legend drugs and two types of non-legend drugs (insulin and pediatric vitamins) if prescribed by physician. No other limitations. No requirements for prior authorization. Reimbursement on basis of wholesale cost plus \$2 service fee. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).</p>
<b>14. Prosthetic Devices</b>	<p><b>a. Eyeglasses</b></p> <p>Not provided.</p> <p><b>b. Hearing Aids</b></p> <p>Not provided.</p> <p><b>c. Dentures</b></p> <p>Not provided.</p> <p><b>d. Other Prosthetic Devices</b></p> <p>Provided. Limited to persons age 65 or older covered by State's buy-in agreement. Consisting of devices to replace all or part of an internal organ, and other devices available as benefits under Part B, Title XVIII (Medicare). No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices when provided under supervision of a physician. No limitations. No requirements for prior authorization. Reimbursement to physician on basis of usual and customary charges; to pharmacist on basis of wholesale cost plus \$2 service fee. Claims processed and paid by fiscal agent (Blue Cross and Blue Shield of Delaware, Inc.).
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Not provided.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Not provided.
<b>b. Other</b>	Not provided.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as 10 days prior to date of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	<ul style="list-style-type: none"> <li>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of the father.</li> <li>(2) Child in AFDC foster care.</li> <li>(3) Child in foster home or private institution for whom a public agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</li> <li>(4) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</li> <li>(5) Person who is blind (State definition) and age 18 or older.</li> <li>(6) Person who is permanently and totally disabled (State definition) and age 18 or older.</li> <li>(7) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</li> </ul>

C. Eligibility for Medical Assistance (Continued)	
b. Age 21 to 64	<ul style="list-style-type: none"> <li>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</li> <li>(2) Person who is blind (State definition).</li> <li>(3) Person who is permanently and totally disabled (State definition).</li> <li>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</li> </ul>
c. Age 65 or older	<ul style="list-style-type: none"> <li>(1) Individual who has attained age 65.</li> </ul>
3. Coverage of the Categorically Needy	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <ul style="list-style-type: none"> <li>a. FFP Claimed in Medical and Administrative Costs <ul style="list-style-type: none"> <li>(1) Recipients of OAA, AB, APTD, and AFDC.</li> <li>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</li> <li>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</li> </ul> </li> </ul> <p style="text-align: center;"><i>Optional</i></p> <ul style="list-style-type: none"> <li>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</li> <li>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</li> <li>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</li> <li>(7) All children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part.</li> <li>(8) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only)</li> </ul>
b. FFP Claimed in Administrative Costs Only	<p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
4. Coverage of the Medically Needy	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a., above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with regulations.</p> <p>[Ed. Note: Prior to publication, coverage of "medically needy" persons was eliminated from the program, effective May 14, 1970.]</p>



**C. Eligibility for Medical Assistance (Continued)**

<p><b>5. Financial Criteria</b></p> <p><b>a. For Categorically Needy Persons</b></p> <p><b>b. For Medically Needy Persons</b></p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>(1) <i>Income</i> Annual income which may be retained for basic maintenance needs: \$1500 for one person, \$2100 for family of 2, \$2700 for 3, \$3300 for 4, \$3800 for 5, \$4300 for 6, \$4800 for 7, \$5200 for 8, \$5600 for 9, \$6000 for 10, plus \$200 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$10 per month for personal expenses.</p> <p>Additional income may be applied to maintenance needs of dependents up to \$1500 for one dependent, \$2100 for 2 dependents, and higher amounts (according to progression stated in preceding paragraph) for additional dependents.</p> <p>(2) <i>Resources</i> Real property used as a home is exempt regardless of value. Other real property may be retained if used to produce income.</p> <p>The following personal property is exempt regardless of value: Household effects, personal clothing, and an automobile essential to travel.</p> <p>Amounts paid for health or medical insurance premiums is disregarded up to \$150 per year for one person, \$250 for 2, or \$350 for 3 or more persons.</p> <p>Other resources (e.g., non-home, non-income producing real property, bank accounts, stocks, bonds, mortgages, and other liquid assets) may be retained up to the following amounts: For one person, to value of \$600, plus \$500 in cash surrender value of life insurance; for 2 persons, to value of \$900, plus \$1000 in cash surrender value of life insurance; plus \$100 for each additional person (but no change in \$1000 maximum on life insurance). Excess value of life insurance is applied against resources maximum.</p> <p>Possession of resources in excess of allowable amounts precludes eligibility, with one exception: Excess real property may be held if offered for sale.</p>
<p><b>6. Financial Responsibility of Relatives</b></p>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under 21 or blind or permanently and totally disabled.</p>
<p><b>7. Identification to Vendors of Persons Eligible</b></p>	<p>A stub attached to the monthly public assistance check serves as a Medical Service Card and certifies eligibility of the addressee for medical assistance during the month indicated. Individuals not receiving a money payment receive a six-month card from the State agency certifying as to their eligibility as "medically indigent." A similar type of card is issued each six months certifying to the eligibility for medical assistance of children in foster care. Case identification number appears on all cards.</p>

**D. Administration and Management**

<p><b>1. Medical Assistance Unit</b></p>	<p>The Chief of the Medical Services Division (medical assistance unit), who is qualified in social work administration, is directly responsible to the Director of the Department of Public Welfare. The professional staff of the Division consists of full-time Medical Social Work Consultant (MSW) and the following part-time staff: a Medical Consultant (M.D.), a Pharmaceutical Consultant, a Dental Consultant, and a Pediatrician. In the 3 county offices the full-time services of a social work supervisor, 4 social workers and a social worker aide are devoted to the medical assistance program.</p>
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**D. Administration and Management (Continued)**

<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the regular field staff of the Department of Public Welfare, supplemented by the part-time services of one supervisor (social work) and 8 medical or para-medical consultants.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Advisory Committee. It is composed of 12 members appointed by the State Board of Public Welfare. There are 5 ex officio members: Chairman, State Board of Welfare; Executive Secretary, State Board of Health; representatives of Regional Medical Program and the State Medical Society; and a Medical Consultant. Authority for the Committee is statutory.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State agency fulfills its administrative responsibility for the review and payment of claims through contract with fiscal agents. (See sub-item b. below.)
<b>b. Fiscal Agents</b>	Department of Public Welfare has entered into a contract, on behalf of the State of Delaware, with Blue Cross and Blue Shield of Delaware, Inc., as fiscal agents to process and pay all claims from providers of medical services.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Delaware as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.00.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually. Unobligated balance may not be carried over but reverts to the General Fund at the end of each fiscal year.
<b>4. Deficit Financing</b>	There is no authority for deficit financing, but if additional funds are needed before the next appropriation period, supplementary legislation may be sought. The Director of the Department requests a supplemental appropriation.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Health

January 1, 1970

DISTRICT OF COLUMBIA

## A. General Information

1. Legal Base	Public Law 90 - 227, 90th Congress.
2. Beginning Dates	Program went into operation on July 1, 1968. Original plan approved by the Federal agency on September 17, 1968.
3. Administrative Responsibility	<p>The Department of Public Health serves as the single State agency with responsibility for administering the program.</p> <p>The Department of Public Welfare is responsible for the determination of eligibility and related aspects of the program.</p>
4. Historical Background	<p>Vendor payments with Federal financial participation under the public assistance programs began first in October 1957. Prior to that time, medical care for persons who could not pay for it was provided through a separate program under the administration of the Department of Public Health. Therefore the plan submitted by the Department of Public Welfare in 1957 included a contract to purchase from the Department of Public Health inpatient hospital care and physicians' services for OAA recipients. For recipients of AB, APTD, and AFDC, hospitalization was provided through facilities administered through the Department of Public Welfare. For all four categories, the Department of Public Welfare made payments directly to the suppliers of other kinds of care: dental services, certain prescribed drugs, and sick-room supplies and appliances. Dentures were provided primarily through the Dental Schools and through a philanthropic foundation, although the public assistance funds paid for dental X-rays and laboratory tests. Later the agency began to make vendor payments for nursing home care in D.C. Village, with allowances for care in other facilities being made through the money payment for total needs.</p> <p>Amendments to the District of Columbia appropriation in 1962 made it possible for the agency to begin a program of Medical Assistance for the Aged (MAA) in January 1963 (a Federal-State program for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need). The services under this program, also, were provided by the State Department of Public Health as the supplier under contract to the Department of Public Welfare. The services included: inpatient hospital care, physicians' services, dental care, prescribed drugs, outpatient services, and home health care. All of these were limited to facilities operated by or under contract to the Department of Public Health or to practitioners available under the Home Care or Health Maintenance services of that agency. The Department of Public Welfare provided nursing home care through its facility in D.C. Village.</p> <p>Some modification of these programs were made to coordinate with services available to persons age 65 and older under title XVIII, but otherwise the programs continued until the beginning of the title XIX program in 1968.</p>
5. Scope of Coverage	Program provides coverage for both categorically needy and medically needy persons. (See Items C. 3. and C. 4.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older (Items B.1.b. and c; B. 4. b. and c.).</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B. 5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B. 12. a., b., and c., and B. 14. d.)</p>



**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. In participating hospitals. Services in connection with dental or oral surgery limited to emergency repair of accidental injury to jaw and related structures. Prior authorization by State agency required for services in connection with cosmetic surgery (except for emergency repair of accidental injury). Reimbursement on basis of reasonable cost. Claims processed and paid by District of Columbia Department of Public Health.</p> <p>Provided. Limited to patients age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by District of Columbia Department of Public Health.</p> <p>Provided. Limited to patients age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by District of Columbia Department of Public Health.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. In participating hospitals. Services in connection with dental or oral surgery limited to emergency repair of accidental injury to jaw and related structures. Prior authorization by State agency required for services in connection with cosmetic surgery (except for emergency repair of accidental injury). Reimbursement on basis of predetermined rate based on cost. Claims processed and paid by District of Columbia Department of Public Health.</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. In participating laboratories. X-ray, radium, and radioactive isotope therapy provided only in facilities approved for such therapy by State agency. Services in connection with dental or oral surgery limited to emergency repair of accidental injury to jaw and related structures. Prior authorization by State agency required for services in connection with cosmetic surgery (except for emergency repair of accidental injury). Reimbursement on basis of predetermined fee-for-service. Claims processed and paid by District of Columbia Department of Public Health.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For persons of all ages. No limitations. No requirements for prior authorization. Reimbursement on basis of negotiated per diem rate. Claims processed and paid by District of Columbia Department of Public Health.</p> <p>Not provided.</p> <p>Provided. Limited to persons age 65 or older in public or private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by District of Columbia Department of Public Health.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. By participating physicians. Elective procedures requiring general anesthesia provided only when performed in a facility accredited for such procedures. Prior authorization by State office required for surgical procedures for cosmetic purposes (except for emergency repair of accidental injury). Reimbursement on basis of predetermined fee-for-service. Claims processed and paid by District of Columbia Department of Public Health.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>	<p>Provided. Routine foot care excluded. No requirements for prior authorization. Reimbursement on basis of predetermined fee-for-service. Claims processed and paid by District of Columbia Department of Public Health.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Optometrists</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of predetermined fee-for-service. Claims processed and paid by District of Columbia Department of Public Health.
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of predetermined fee-for-service. Claims processed and paid by District of Columbia Department of Public Health.</p> <p>(b) Services of home health aide. Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of predetermined fee-for-service. Claims processed and paid by District of Columbia Department of Public Health.</p> <p>(c) Medical supplies, equipment, and appliances. Provided; but only those appliances which are owned or rented by the Home Health Agency and loaned to the patient to facilitate his treatment and rehabilitation. No other limitations. No requirement for prior authorization. Reimbursement on basis of inclusion as an element of cost in determining the fees to be paid for services provided by Home Health Agencies. Claims processed and paid by District of Columbia Department of Public Health.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services</b>	Provided. Services in connection with dental or oral surgery limited to emergency repair of accidental injury to jaw and related structures. Prior authorization by State agency required for services in connection with cosmetic surgery (except for emergency repair of accidental injury). Reimbursement on basis of predetermined all-inclusive rate-per-visit, based on cost. Claims processed and paid by District of Columbia Department of Public Health.
<b>11. Dental Services</b>	Not provided.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement and to such services when available as Medicare benefits or when provided by a Home Health Agency to any Medicaid eligible. No requirements for prior authorization. Reimbursement on basis of predetermined fee-for-service. Claims processed and paid by District of Columbia Department of Public Health.
<b>b. Occupational Therapy</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement and to such services when available as Medicare benefits or when provided by a Home Health Agency to any Medicaid eligible. No requirements for prior authorization. Reimbursement on basis of predetermined fee-for-service. Claims processed and paid by District of Columbia Department of Public Health.
<b>c. Speech Therapy</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement and to such services when available as Medicare benefits or when provided by a Home Health Agency to any Medicaid eligible. No requirements for prior authorization. Reimbursement on basis of predetermined fee-for-service. Claims processed and paid by District of Columbia Department of Public Health.
<b>d. Audiology</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs. Limited to items listed in Drug Formulary. No requirements for prior authorization. Reimbursement for legend items on basis of cost plus \$1.50 dispensing fee; of non-legend items on basis of cost plus 50%. Claims processed and paid by District of Columbia Department of Public Health.
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Provided. Limited to one pair upon examination. No requirements for prior authorization. Reimbursement on basis of laboratory cost. Claims processed and paid by District of Columbia Department of Public Health.
b. Hearing Aids	Not provided.
c. Dentures	Not provided.
d. Other Prosthetic Devices	Provided. Limited to persons age 65 or older covered by State's buy-in agreement and to such items when received as Medicare benefits. Reimbursement on basis of that portion of patient's liability not paid by Medicare. Claims processed and paid by District of Columbia Department of Public Health.
<b>15. Family Planning Services</b>	Provided. No limitations. No requirements for prior authorization. Basis of reimbursement variable according to provider utilized. Claims processed and paid by District of Columbia Department of Public Health.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Limited to period of emergency. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by District of Columbia Department of Public Health.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
a. Ambulance	Not provided.
b. Other	Not provided.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the third month preceding the month of application provided all conditions of eligibility were met in the month in which services were rendered.
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**C. Eligibility for Medical Assistance (Continued)**

<b>2. Conditions of Eligibility</b> <b>(By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C. 3. a.
<b>a. Under Age 21</b>	(1) Individual under age 21.
<b>b. Age 21 to 64</b>	(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent. (2) Person who is blind (State definition). (3) Person who is permanently and totally disabled (State definition). (4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> (1) Recipients of OAA, AB, APTD, and AFDC. (2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX. (3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan. <p style="text-align: center;"><i>Optional</i></p> (4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC. (5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility. (6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C. 3.a. (3), above, are living. (7) All individuals under age 21. (8) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only.)
<b>b. FFP Claimed in Administrative Costs Only</b>	<p style="text-align: center;"><i>Optional</i></p> (1) Individuals who are being maintained in any public institution except while patients in a medical institution. (2) Individuals under the age of 65 who are receiving medical assistance while patients in institutions for tuberculosis or mental diseases. (3) Spouse of an individual who is eligible as medically needy under the State's program, provided the spouse is living with and has been determined essential to the well-being of such medically needy person.

**C. Eligibility for Medical Assistance (Continued)**

<b>4. Coverage of the Medically Needy</b>	Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in items C. 3, a. and b. above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD, and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C. 5. b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with regulations.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	<p>(1) <i>Income</i> Annual income which may be retained for basic maintenance needs: \$2100 for one person, \$2800 for family of 2, \$3180 for 3, \$3560 for 4, and \$420 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain only \$20 a month for personal expenses unless maintaining a home in which one or more other individuals dependent upon such income is living, or to which it is reasonable to assume he will return.</p> <p>(2) <i>Resources</i> Home may be retained regardless of value. Personal effects, household furnishings, an automobile, and property (both real and personal) used to produce income are exempt.</p> <p>Other liquid reserves (such as cash, bank accounts, saving accounts, cash surrender value of life insurance, and other assets convertible to cash) may be retained up to a value of \$2500 for one person plus \$100 for each additional family member.</p> <p>Resources in excess of these amounts or ownership of any non-home, non-income-producing real property disqualify applicant from receiving medical assistance under the program.</p>
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.
<b>7. Identification to Vendors of Persons Eligible</b>	The "Medical Care Identification Pass," a white plastic card with black lettering and blue embossed items of identification, is issued by the Medical Eligibility Division, D.C. Department of Public Welfare, to each eligible person. The first issuance is for a period of not less than 6 months and not more than 1 year. Renewal is usually for a period of 1 year. Face of card shows name, birthdate of eligible person, and dates of eligibility. An unique code number identifies the individual, his particular family group, and the segment(s) of the program(s) to which he relates. The back of the card lists seven points of information about the card and its use.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The unit is directed by the Associate Director for Medical Care, a physician, who is directly responsible to the Director of Public Health. The other full-time professional staff of the unit consists of: an Executive Assistant to the Director and a Chief of Bureau of Processing and Review (both from the field of administration), Chief of Bureau of Patients' Services (social work and public health), Chief of Bureau of Resources Development, (M.D.), Nursing Consultant (R.N.), a Pharmacy Consultant, and a Training Officer (field of personnel). There is also a part-time Dental Consultant.
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**D. Administration and Management (Continued)**

<b>2. Supervision of Statewide Operations</b>	<p>Supervision of the medical aspects of operations is accomplished by the medical assistance unit and subordinate staff (Medical Care), and consultants (various disciplines) in conjunction with the regular supervisory staff of the Department of Public Health.</p> <p>Supervision of eligibility determination and related aspects of the program is by the regular staff of the Department of Public Welfare.</p>
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Care and Hospitals Subcommittee of State Health Planning Advisory Committee. It is composed of 100 members appointed by the Chairman of the Health Planning Advisory Committee. There are no ex officio members. Authority for the Committee is administrative.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under both title XVIII of the Social Security Act and the State's title XIX program.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The District of Columbia Department of Public Health processes and pays claims from all providers of medical care and services under the title XIX plan.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for the District of Columbia as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.00.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually by the U.S. Congress for the District of Columbia budget. Unobligated balance may not be carried over at the end of the fiscal year.
<b>4. Deficit Financing</b>	There is no authority for deficit financing.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health and  
Rehabilitative Services

January 1, 1970

FLORIDA

**A. General Information**

<b>1. Legal Base</b>	Section 409.268, Chapter 409 Florida Statutes Annotated.
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1970. Original plan approved by the Federal agency on December 31, 1969.
<b>3. Administrative Responsibility</b>	The Department of Health and Rehabilitative Services serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices (12 district administrators).
<b>4. Historical Background</b>	<p>The State first made vendor payments under the Federal-State public assistance programs in October 1956, limited to the cost of hospitalization in all four programs. A "pooled fund" from which such payments were made was maintained until June 1957, when the program was discontinued. From September 1958 to October 1959, the only service was prescribed drugs for the adult programs. In 1959, inpatient hospital care for all four categories was resumed and the provision of prescribed drugs was continued for recipients of OAA, AB, and APTD. In 1961, vendor payment for nursing home care for the OAA program was added; and in 1963 this service was extended to the other two adult categories when the State chose to administer aid under the new pattern of Aid to the Aged, Blind, or Disabled as one category.</p> <p>Legislation effective July 1, 1963, authorized a Federal-State program of Medical Assistance for the Aged, for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. The scope of care consisted of inpatient hospital care and "visiting nurse care by registered nurse or licensed practical nurse of an organization approved by the State Board of Health." A written agreement which was developed at this time between the welfare agency and the State Board of Health provided that the latter should provide medical direction "together with specified administrative services dealing with validation of claims filed for vendor payment to suppliers."</p> <p>The MAA program was discontinued June 30, 1966, when the Medicare amendment to the Social Security Act (title XVIII) became effective. In that same year, services for the AABD program were modified to assure the most economical use of the provisions of Medicare for eligible persons age 65 and over, and the authority for prescribed drugs was extended to AFDC recipients. These provisions were continued until the implementation of the Medicaid (title XIX) program in January 1970.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B.7.a.; B.8.(a), (b), and (c); B.10; B.12.a., b., and c.; B.14.)</p> <p>Certain services covered as benefits under Medicare are made available on a more liberal basis to individuals covered by the State's buy-in agreement than to others, (Items B.2. and B.3.).</p>

**B. Medical and Remedial Care and Services**

<p><b>1. Inpatient Hospital Services</b></p> <p><b>a. In General Hospitals</b></p> <p><b>b. In Institutions for Tuberculosis</b></p> <p><b>c. In Institutions for Mental Diseases</b></p>	<p>Provided. Limited to maximum of 45 days per fiscal year; in hospitals which have entered into a participation agreement with the State agency. Attending physician's certification and periodic recertification of medical necessity required. Payment made for private room if ordered by physician as medically essential. Authorization through Statewide rapid communications network (directly connected to a central computer) required. Under this system, hospital telephones a video data terminal operator to obtain a "transaction number" when patient is admitted and when discharged, as well as at beginning of each State fiscal year and (if different) the hospital's fiscal year. Receipt of transaction number constitutes authorization. Reimbursement on basis of reasonable cost (per diem rate based on last audit plus 12% in lieu of retroactive adjustment). Claims for Medicare deductible processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.). All other claims processed by State agency's Division of Family Services; paid by State Comptroller.</p> <p>Provided. Limited to persons age 65 or older in public institutions. No other limitations. Authorization by local office required (i.e., upon admission or discharge of patient or upon change in monthly payment rate, unit caseworker telephones a video data terminal operator and makes input into Statewide rapid communications network which is directly connected to a central computer). Reimbursement on basis of reasonable cost. Claims for Medicare deductible processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.). All other claims processed by State agency Bureau of Adult Services and Bureau of Systems and Procedures; paid by State agency Bureau of Finance and Accounts.</p> <p>Provided. Limited to persons age 65 or older in public institutions. No other limitations. Authorization by local office required (i.e., upon admission or discharge of patient or upon change in monthly payment rate, unit caseworker telephones a video data terminal operator and makes input into Statewide rapid communications network which is directly connected to a central computer). Reimbursement on basis of reasonable cost. Claims for Medicare deductible processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.). All other claims processed by State agency Bureau of Adult Services and Bureau of Systems and Procedures; paid by State agency Bureau of Finance and Accounts.</p>
<p><b>2. Outpatient Hospital Services</b></p>	<p>Provided. Preventive, diagnostic, therapeutic, and palliative services, under direction of a physician. In hospitals which have entered into a participation agreement with the State agency, for Medicaid recipients (not eligible for Medicare) services will be provided up to \$100 per recipient with an additional allowance if attending physician requests special consideration and the request is approved by the State Office. Within the normal \$100 limit, prior authorization for each "occasion of service" is required through the medium of a Statewide rapid communications network which is directly connected to a central computer. (Under this system, provider telephones a video data terminal operator to obtain a "transaction number", which constitutes the authorization.) Reimbursement on basis of reasonable charge. For those recipients over 65 eligible for Medicare, there are unlimited services but with the requirement for prior authorization for each "occasion of service" as for those recipients under 65. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.). All other claims processed by State agency's Division of Family Services; paid by State Comptroller.</p>
<p><b>3. Other Laboratory and X-ray Services</b></p>	<p>Provided. For Medicaid recipients (not eligible for Medicare), limited to \$50 per person fiscal year. Prior authorization for each "occasion of service" required through the medium of a Statewide rapid communications network which is directly connected to a central computer. (Under this system, provider telephones a video data terminal operator or local welfare office to obtain a "transaction number", which constitutes the authorization.) Reimbursement on basis of fee schedule. Unlimited services when received as Medicare benefits by persons if 65 or older, but with the same requirement for prior authorization for each "occasion of service" as for those recipients under 65. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.). All other claims processed by State agency Bureau of Family Services; paid by State Comptroller.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>          <b>b. In Institutions for Tuberculosis</b>   <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to persons age 21 or older. Prior authorization by State office required (obtained through local unit caseworker who telephones "video terminal" and obtains a transaction number from the Statewide rapid communications network which is directly connected to a central computer). Reimbursement on basis of allowed maximum rate. Maximum State payment \$300 per month; maximum recognized cost, \$350. Supplementation of State payment up to recognized cost allowed from a relative or other third party except other State or county governmental units. Claims processed by State agency Division of Family Services; paid by State Comptroller.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>
<b>6. Physician's Services (M.D. and D.O.)</b>	<p>Provided. Unlimited services except for exclusion of routine physical examinations, routine eye examinations, routine immunizations, internal organ transplants and clinically unproven procedures. For Medicaid recipients (not eligible for Medicare), prior authorization required for each "occasion of service" through the medium of a Statewide rapid communications network which is directly connected to a central computer. (Under this system, physician telephones a video data terminal operator to obtain a "transaction number", which constitutes the authorization.) Reimbursement on basis of usual and customary fees, subject to 75th percentile limitation. Unlimited services for persons over 65 eligible for Medicare but with the same requirement for prior authorization on each "occasion of service". Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.). All other services processed by State agency Division of Family Services; paid by State Comptroller.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>      <b>b. Optometrists</b>  <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Provided. Limited to persons age 65 or older when received as a Medicare benefit. Same requirement for prior authorization on each "occasion of service"; reimbursement on basis of reasonable charges as determined by the Medicare carrier. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.).</p> <p>Not provided.</p> <p>Not provided.</p> <p>Not provided.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided for persons age 65 or older when received as a Medicare benefit. Reimbursement to home health agency on basis of reasonable cost as determined by Medicare carrier. Provided those under 65, and those over 65 not eligible for Medicare. Reimbursement on basis of fee schedule. Prior authorization required for each month of service through the medium of a statewide rapid communications network connected directly to a central computer. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.). All other claims processed by Division of Family Services and paid by State Comptroller.</p> <p>[For recipients of AABD who are living outside of an institution, an amount may be recognized in the assistance budget as a special needs item for cost of nursing care, as paid, up to \$246 a month; within maximum limit of \$114 per month on total amount of the assistance payment.]</p> <p>(b) Services of home health aide. Provided for persons age 65 or older when received as a Medicare benefit. Reimbursement to home health agency on basis of reasonable cost as determined by Medicare carrier. Provided those under 65, and those over 65 not eligible for Medicare. Reimbursement on basis of fee schedule. Prior authorization required for each month of service through the medium of a statewide rapid communications network connected directly to a central computer. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.). All other claims processed by Division of Family Services and paid by State Comptroller.</p> <p>[For recipients of AABD who are living outside of an institution, an amount may be recognized in the assistance budget as a special needs item for services of a health aide, as paid, up to \$169 per month; within maximum limit of \$114 per month on total amount of the assistance payment.]</p> <p>(c) Medical supplies, equipment, and appliances. Provided only for persons age 65 or older when received as Medicare benefits. Prior authorization required through the medium of a statewide communications network which is directly connected to a central computer. Reimbursement on basis of reasonable charges as determined by Medicare carrier. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.).</p> <p>[For recipients of AABD who are living outside of an institution, an amount may be recognized in the assistance budget as a special needs item for medical dressings, supplies, appliances, and prosthetic devices, as paid, up to \$10 per month; within maximum limit of \$114 per month on total amount of the assistance payment.]</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. Limited to persons age 65 or older when received as a Medicare benefit. Prior authorization required through the medium of a statewide rapid communications network connected to a central computer. Reimbursement on basis of reasonable charges as determined by Medicare carrier. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida Inc., and Blue Shield of Florida, Inc.).</p>
<b>11. Dental Services</b>	<p>Not provided.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>12. Physical Therapy and Related Services</b>  <b>a. Physical Therapy</b>   <b>b. Occupational Therapy</b>   <b>c. Speech Therapy</b>   <b>d. Audiology</b>	<p>Provided. Limited to persons age 65 or older when received as a Medicare benefit. Prior authorization required on each "occasion of service." Reimbursement on basis of reasonable cost or reasonable charges, as determined by Medicare carrier. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.).</p> <p>Provided. Limited to persons age 65 or older when received as a Medicare benefit. Prior authorization required on each "occasion of service." Reimbursement on basis of reasonable cost or reasonable charges, as determined by Medicare carrier. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.).</p> <p>Provided. Limited to persons age 65 or older when received as a Medicare benefit. Prior authorization required on each "occasion of service." Reimbursement on basis of reasonable cost as determined by Medicare carrier. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.).</p> <p>Not provided.</p>
<b>13. Prescribed Drugs</b>	<p>Provided. Legend drugs only. Allowance of \$20 per month for each eligible recipient. (For further information on "Certificate of Eligibility for Prescribed Drugs," see Item C.7.) Prior authorization by State office required for increase allowance. Payment made only to pharmacies with a signed participation agreement. Reimbursement on basis of cost plus percentage mark-up ("Prescription Schedule" of average prices which include the professional fee, according to volume or weight of liquids, capsules, powders, etc.); payment not to exceed usual charge to general public. Claims processed by State agency Bureau of Family Services; paid by State Comptroller.</p>
<b>14. Prosthetic Devices</b>  <b>a. Eyeglasses</b>   <b>b. Hearing Aids</b>   <b>c. Dentures</b>   <b>d. Other Prosthetic Devices</b>	<p>Not provided.</p> <p>[For recipients of AABD who are living outside of an institution, an amount may be recognized in the assistance budget as a Special Needs item for medical dressings, supplies, appliances, and prosthetic devices, as paid, up to \$10 per month; within maximum of \$114 per month on total amount of the assistance payment.]</p> <p>Not provided.</p> <p>[For recipients of AABD who are living outside of an institution, an amount may be recognized in the assistance budget as a Special Needs item for medical dressings, supplies, appliances, and prosthetic devices, as paid, up to \$10 per month; within maximum of \$114 per month on a total amount of the assistance payment.]</p> <p>Not provided.</p> <p>Provided. Limited to persons age 65 or older when received as Medicare benefits. Prior authorization required on each "occasion of service." Reimbursement on basis of reasonable charges as determined by Medicare carrier. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.).</p> <p>[For recipients of AABD who are living outside of an institution, an amount may be recognized in the assistance budget as a special needs item for medical dressings, supplies, appliances, and prosthetic devices, as paid, up to \$10 per month; within maximum limit of \$114 per month on total amount of the assistance payment.]</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>15. Family Planning Services</b>	Provided. No limitations. Prior authorization by local office required for physicians' services. Reimbursement to physicians on basis of fee schedule. Claims processed by State agency Division of Family Services; paid by State Comptroller.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Inpatient and outpatient hospital services of an emergency nature provided by a hospital which is licensed by the State agency but for which there is no participation agreement. Prior authorization required on each "occasion of service." Reimbursement based on 85% of reasonable charges. Claims processed by State agency Division of Family Services; paid by State Comptroller.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. When medically necessary, and furnished to persons age 65 and older as a Medicare benefit; for others, authorization from local office required for each one-way or round trip. Prior authorization required on each "occasion of service." Reimbursement on basis of fee schedule. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc.). All other claims processed by State agency's Bureau of Finance and Accounts; paid by State Comptroller.
<b>b. Other</b>	Provided. By common carrier or private vehicle. No limitations. Prior authorization by local office required. Reimbursement on basis of fee system. Claims processed by State Department Bureau of Finance and Accounts; paid by State Comptroller.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the date of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	<ul style="list-style-type: none"> <li>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</li> <li>(2) Child in AFDC Foster Care.</li> <li>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</li> <li>(4) Person who is blind (State definition).</li> <li>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</li> </ul>





### C. Eligibility for Medical Assistance (Continued)

<b>7. Identification to Vendors of Persons Eligible</b>	<p>A "Recipient Identification Card" is issued quarterly by the State agency's Division of Family Services to each single case or family certified as eligible under the program. Card shows family name (last name) and family number, as well as the first name and month and year of birth of each eligible family member. Card carries an expiration date. It does not constitute proof of eligibility but is designed primarily to furnish basic identification information needed by providers to verify eligibility through use of the Statewide computerized rapid communication system.</p> <p>In addition, each case receives a "Certificate of Eligibility for Prescribed Medicine," which is issued monthly by the State agency's Division of Family Services and which certifies to the eligibility of the case for \$20 worth of prescribed medicine during the month indicated. The month for which valid, case number, and names of family members eligible for medicine are shown on the face of the certificate which also has a printed form for the recording of information by the pharmacist (prescription number, date, drug code, quantity, and price) concerning each prescription filled. Recipient presents this certificate to the pharmacy of his choice, which he may elect to change from month to month, but not within a month. Upon presentation, the pharmacy retains the certificate both as a means of control on the \$20 limitation and for use as a billing form at the end of the month.</p>
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### D. Administration and Management

<b>1. Medical Assistance Unit</b>	<p>The Chief of the Bureau of Medical Services (the medical assistance unit) is a social worker (MSW) who is responsible to the Deputy Director of the Division of Family Services. The other full-time professional staff of the unit are: a physician (M.D.), a Medical Services Administrator (MS), 2 Assistant Medical Services Administrators (B.A.), 2 Pharmacists, a Welfare Program Supervisor (MSW), a Nursing Home Consultant (B.A.), and a Social Worker - Planning (MSW). There are also the services of two part-time consultants: a physician and a dentist.</p>
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of the medical aspects of Statewide operations is accomplished through 4 supervisory positions (listed in D.1. above) in the Bureau of Medical Services (Chief of the Bureau of Medical Services, Medical Services Administrator, and 2 Assistant Medical Services Administrators) and 34 consultants assigned in the 12 District offices: 1 full-time Welfare Consultant (MSW) in each District, 1 full-time caseworker in each of 11 Districts with 2 in the other District, and the equivalent (in service-hours) of 9 full-time physicians among the 12 Districts (some have a full-time and some only a part-time physician).</p> <p>Supervision of the eligibility determination aspects of the Statewide operations is accomplished through the regular full-time staff of the 12 District offices and 10 supervisors, working out of the State office in the Bureaus of Adult Services and of Children Services. In addition there are 5 Statewide consultants, 2 in the Adult Services Bureau and 3 in the Children Services Bureau.</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Medicaid Advisory Group. It is composed of 38 members appointed by the Secretary, State Department of Health and Rehabilitative Services. There is one ex officio member (Assistant Secretary of Health and Medical Services, Department of Health and Rehabilitative Services) without voting privileges. Authority for the Group is administrative.</p>
<b>4. Buy-In Agreement</b>	<p>State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.</p>
<b>5. Claims Payment Process</b> <b>a. State and Local Agencies</b>  <b>b. Fiscal Agents</b>	<p>State agency processes and the Comptroller pays all claims for services provided under the program except those for Medicare deductibles and coinsurance, which are handled by a fiscal agent.</p> <p>State agency has entered into a fiscal agent contract with Blue Cross of Florida, Inc. and Blue Shield of Florida, Inc. under the terms of which the fiscal agent processes and pays all claims for amounts owing as Medicare deductibles and coinsurance on claims for services provided to recipients age 65 or older.</p>

**D. Administration and Management (Continued)**

<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Florida as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 64.10.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration. However each county is required to repay to the State 35% of all costs of inpatient hospitalization after the first 12 days per patient per year, and 35% of the costs of nursing home care paid in excess of \$120 a month, for each eligible county resident, regardless of the location of the hospital or nursing home.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually specifically for title XIX program. Unobligated balance reverts to the General Fund at the end of the fiscal year.
<b>4. Deficit Financing</b>	If additional funds are needed before the next appropriation period, agency may, with Budget Bureau approval, transfer funds from other appropriations of the agency; but such transfer is limited to funds actually appropriated or approved by the Budget Bureau.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Health

January 1, 1970

GEORGIA

**A. General Information**

<b>1. Legal Base</b>	Section 88-108 and 88-111 of the Georgia Code Annotated, and Executive Order of the Governor dated August 2, 1967. [Act No. 582, Laws of 1967, amending Georgia Public Assistance Act of 1965, provided for implementation of a title XIX program.]
<b>2. Beginning Dates</b>	Program went into operation on October 1, 1967. Original plan approved by the Federal agency on September 25, 1967.
<b>3. Administrative Responsibility</b>	The Georgia Department of Public Health is the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices. Determination of eligibility for medical assistance is made by the 159 County Departments of Family and Children Services under the supervision of the State Department of Family and Children Services. By written agreement between the two agencies, the State Department of Family and Children Services also provides social services to recipients of Medical Assistance as required in a program under title XIX.
<b>4. Historical Background</b>	The first program of vendor payments for the cost of medical care with Federal financial participation as part of the public assistance program began in January 1962. Although authorizing legislation was broad enough to permit a comprehensive scope of services, limitation of funds prevented full implementation. The program began, therefore, with inpatient hospital services and nursing home care for OAA recipients. Later that same year it was extended to recipients of AB and APTD. Legislation in 1963 authorized vendor payments for medical care for recipients of AFDC, but it was not implemented until July 1965 when payments for hospitalization began. A prescription drug program for all Federally-aided categories was initiated in October 1966. Neither physicians' services nor dental care was provided prior to inception of the program under title XIX. Implementation of a program of Medical Assistance for the Aged under title I of the Social Security Act was never undertaken by the State.
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only.
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all eligible individuals with the following exceptions:</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement, i.e., podiatrists' services (Item B. 7. a.) and services of home health aides (Item B. 8. b.).</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. No limitations. Length of hospital stay covered is based on medical justification and findings of hospital utilization review committee. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Health.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations, but services must be under supervision of physician. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Health.

**B. Medical and Remedial Care and Services (Continued)**

<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations, but services must be by prescription or order of physician. No requirements for prior authorization. Reimbursement on basis of reasonable charges (title XVIII standards and principles). Claims processed and paid by State Department of Public Health.
<b>4. Skilled Nursing Home Services</b>	
a. General	Provided. For persons of all ages. No limitations, but must be on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of billing rate related to cost and negotiated with each provider, but with actual payment limited to maximum State pay rate for licensure classification of the home. Supplemental payment to nursing home (by relative or other source) permitted up to negotiated monthly billing rate. Claims processed and paid by State Department of Public Health.
b. In Institutions for Tuberculosis	Not provided.
c. In Institutions for Mental Diseases	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. Treatment of mental diseases limited to maximum of \$250 per calendar year. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charges (title XVIII standards and principles). Claims processed and paid by State Department of Public Health.
<b>7. Services of Licensed Practitioners</b>	
a. Podiatrists	Provided only for recipients age 65 or older on whose behalf State pays SMI premiums under buy-in agreement. Limitations governing XVIII benefits apply. Reimbursement according to title XVIII standards and principles. Claims processed and paid by State Department of Public Health.
b. Optometrists	Provided only for recipients age 65 or older on whose behalf State pays SMI premiums under buy-in agreement. Limitations governing title XVIII benefits apply. Reimbursement according to title XVIII standards and principles. Claims processed and paid by State Department of Public Health.
c. Chiropractors	Not provided.
d. Other	Psychologist: Provided only for diagnostic services rendered by a licensed psychologist on referral by a licensed physician.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B) are provided to recipient while at home if (1) furnished by a Home Health Agency, (2) in accordance with standards and principles of title XVIII- Medicare, and (3) limited to a total of 100 visits per calendar year for any one or a combination of all services:</p> <p>(a) Intermittent or part-time nursing services. Provided, subject to conditions listed above. No requirements for prior authorization. Reimbursement on basis of a negotiated percentage (not to exceed 100%) of fee schedule established by title XVIII carrier for visits prescribed or ordered by licensed physician. Claims processed and paid by State Department of Public Health.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>(b) Services of home health aide. Provided only for persons covered by the State's buy-in agreement and subject to conditions listed above. No requirements for prior authorization. Reimbursement on basis of a negotiated percentage (not to exceed 100%) of fee schedule established by title XVIII carrier for visits prescribed or ordered by licensed physician. Claims processed and paid by State Department of Public Health.</p> <p>(c) Medical supplies, equipment, and appliances, including purchase or rental of durable medical equipment. Provided only as part of services of Home Health Agency, if prescribed or ordered by physician. Prior authorization required for additional items after purchases for recipient amounting to \$50 in a 6-month period. Reimbursement on basis of reasonable charges. Claims processed and paid by State Department of Public Health.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Not provided.</p>
<b>11. Dental Services</b>	<p>Not provided.</p>
<b>12. Physical Therapy and Related Services</b>  <b>a. Physical Therapy</b>  <b>b. Occupational Therapy</b>  <b>c. Speech Therapy</b>  <b>d. Audiology</b>	<p>Not provided.</p> <p>Not provided.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>13. Prescribed Drugs</b>	<p>Provided. According to State Medical Assistance Drug List (includes a few non-legend drugs). No limitations, except that no more than three refills for any one prescription. No requirements for prior authorization. Reimbursement on basis of unit price on drug list multiplied by number of units dispensed, plus \$1.65 dispensing fee. Claims processed and paid by the State Department of Public Health.</p>
<b>14. Prosthetic Devices</b>  <b>a. Eyeglasses</b>  <b>b. Hearing Aids</b>  <b>c. Dentures</b>  <b>d. Other Prosthetic Devices</b>	<p>Not provided. [However, replacement lenses are provided for aphakic patients.]</p> <p>Not provided.</p> <p>Not provided.</p> <p>Provided: Artificial eyes, arms, legs, braces and certain other prosthetic devices. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charges (title XVIII standards and principles). Claims processed and paid by State Department of Public Health.</p>
<b>15. Family Planning Services.</b>	<p>Not provided.</p>
<b>16. Services of Cristian Science Nurses</b>	<p>Not provided.</p>
<b>17. Care and Services in Christian Science Sanatoria</b>	<p>Not provided.</p>



## B. Medical and Remedial Care and Services (Continued)

18. Emergency Hospital Services (in hospitals not qualified under title XVIII or State's title XIX program)	Not provided.
19. Personal Care Services In Patient's Home	Not provided.
20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services	Not provided.
21. Transportation	
a. Ambulance	Provided. Upon physician's certification that no other means is feasible due to patient's condition. No other limitations. No requirement for prior authorization. Reimbursement on basis of reasonable charges (title XVIII standards and principles). Claims processed and paid by State Department of Public Health.
b. Other	Not provided.

## C. Eligibility for Medical Assistance

1. Date of Entitlement	Upon determination of eligibility, an individual is retroactively entitled to medical assistance as early as the first day of the month in which application is received, provided all conditions of eligibility were met in the month in which services were rendered.
2. Conditions of Eligibility (By Age Groups)	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C. 3. a.:
a. Under Age 21	<p>(1) Child deprived of parental support or care, living with a parent or caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factors:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition) and age 16 or older.</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p>
b. Age 21 to 64	<p>(1) Parent or caretaker relative (as specified in State's AFDC plan), with whom a child deprived of parental support or care is living, provided such child is under 18 years of age. (If age 16 or 17, child must be attending school unless physically or mentally unable to do so.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
c. Age 65 or older	(1) Individual who has attained age 65.
3. Coverage of the Categorically Needy	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
	<i>Mandatory</i>
a. FFP Claimed in Medical and Administrative Costs	<p>(1) Recipients of AABD and AFDC .</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program of medical assistance under title XIX.</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>b. FFP Claimed in Administrative Costs Only</b>	(3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.  <i>Optional</i>  (4) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC program but who would be eligible for such assistance if they left the facility.
	None.
<b>4. Coverage of the Medically Needy</b>	Not included.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	Not applicable.
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children under the age of 21.
<b>7. Identification to Vendors of Persons Eligible</b>	A Medical Eligibility Certification is issued monthly to each eligible individual or family in the form of an attachment to the monthly assistance check (for Medical Assistance Only cases, the check portion is blank). Initial certification is issued by the county department; thereafter, by the State Department of Family and Children Services.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Branch of Medical Assistance (medical assistance unit) is located in the Division of Medical Care Administration of the Department of Public Health. Director (M.D.) of the Branch is responsible to the Director of the Division of Medical Care Administration. In addition to the Director, the full-time professional staff of the Branch consists of a Medical Consultant (M.D.), a Social Work Consultant (M.S.W), and the Director of Medicaid Services (Master's Degree, Hospital Administration) who is the Program Management Officer. Staff of the Medicaid Services includes 2 pharmacists, 3 Drug Program Representatives (auditors), an accountant, 4 Medical Facilities Auditors, and a Medical Records Technician.
<b>2. Supervision of Statewide Operations</b>	Field supervisory consultation and information support is provided by the Department of Public Health through its Office of Local Health and Branch of Health Facilities and Licensure. Statewide supervision of the eligibility and social services aspects of the program is accomplished through the regular field staff of the State Department of Family and Children Services.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Advisory Committee. The Committee consists of 14 members appointed by the Director of the Georgia Department of Public Health. There are no ex officio members. Either the Director, Department of Health, Director, Division of Medical Care Administration, or Director, Branch of Medical Assistance, serves as chairman. Authority for the Committee is administrative (i.e., action of Director, Department of Public Health).
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients (including non-money payment clients) who are eligible for benefits under both title XVIII of the Social Security Act and the State's program under title XIX.

**D. Administration and Management (Continued)**

<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The Department of Public Health makes direct payment to vendors for all medical care and services provided under the program.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Contracts with Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Georgia as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 71.48.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs are derived from earmarked State revenues available to the State Agency. Appropriations are made biennially; unobligated balance reverts at end of biennium.
<b>4. Deficit Financing</b>	When available funds are found insufficient to meet the State's share of program costs, services must be curtailed, because additional funds to meet a deficit cannot be obtained before the next appropriation period.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Health  
and Social Services

January 1, 1970

GUAM

**A. General Information**

<b>1. Legal Base</b>	Sections 9102 and 9103 of Chapter 2, Title X of the Government Code of Guam.
<b>2. Beginning Dates</b>	Program went into operation on November 1, 1967. Original plan approved by the Federal agency on July 20, 1967.
<b>3. Administrative Responsibility</b>	The Department of Public Health and Social Services serves as the single State agency with responsibility for administering the program on a Statewide basis. There are no local offices.
<b>4. Historical Background</b>	Provisions for payment of costs of medical care for recipients of public assistance with Federal financial participation began in February 1962 for the OAA program. Previously, the Division of Public Welfare had no responsibility for medical care in any of its assistance programs, which had begun under the titles of the Social Security Act in July 1959. Traditionally and by law, medical care was furnished by the Medical Services of the Government of Guam without cost to persons who could not pay. The facilities included the Guam Memorial Hospital, with an out-patient department, and 17 health centers throughout the various villages of the Island. Special legislation in 1961 authorized charging the Division of Public Welfare for medical care and services rendered to any recipient "authorized by the Division of Public Welfare to receive such services". The same legislation authorized payments under the program of Medical Assistance for the Aged, a Federal-State program of services for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. The major medical services "critically necessary" were provided under both programs; except that nursing home care was not provided, as such, since there were no nursing homes on the island. However the Guam Memorial Hospital was available for persons needing that kind of care. Legislation in 1964 extended medical vendor payments under the public assistance categories to recipients of AB, APTD, and AFDC, effective August 14, 1964. The MAA program was terminated June 30, 1967, preparatory to the implementation of title XIX.
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:  Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B.7.a., B.12.a., b., and c., B.14.c.)

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by Department of Public Health and Social Services.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by Department of Public Health and Social Services.

**B. Medical and Remedial Care and Services (Continued)**

<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by Department of Public Health and Social Services.
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. Where available. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable costs. Claims processed and paid by Department of Public Health and Social Services.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Health and Social Services.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Limited to persons age 65 or older covered by buy-in agreement, and to such services available as benefits under Medicare, Part B. No requirements for prior authorization. Reimbursement on basis of reasonable costs. Claims processed and paid by State Department of Public Health and Social Services.
<b>b. Optometrists</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Health and Social Services.
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	Not provided.  [Home health care services are provided by Department of Public Health and Social Services at no cost to the general public or to persons who are eligible for Medicaid.]
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	Provided. Where available. [New service added to program January 1970; no details available.]
<b>11. Dental Services</b>	Provided. Upon referral of patient to private dentist by Public Health Dental Clinic. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Health and Social Services.  [Emergency dental treatment and dental services required for effective treatment of medical conditions are provided in Public Health Dental Clinic. Neither patient nor title XIX program is billed for the services. In a few situations, patients are referred to private dentists by clinic personnel, and payment to the dentist made by the title XIX program, as described above.]



**B. Medical and Remedial Care and Services (Continued)**

<b>12. Physical Therapy and Related Services</b>  <b>a. Physical Therapy</b>   <b>b. Occupational Therapy</b>   <b>c. Speech Therapy</b>   <b>d. Audiology</b>	<p>Provided. Limited to persons age 65 or older covered by buy-in agreement; and limited to services available as benefits under Part B of Title XVIII (Medicare). No requirements for prior authorization. Reimbursement on basis of an established fee schedule. Claims processed and paid by State Department of Public Health and Social Services.</p> <p>Provided. Limited to persons age 65 or older covered by buy-in agreement; and limited to services provided by a qualified home health agency, within maximum limit of 100 visits per year of all home health agency visits. No requirements for prior authorization. Reimbursement on basis of an established fee schedule. Claims processed and paid by State Department of Public Health and Social Services.</p> <p>Not provided.</p> <p>[Service is available through Department of Public Health and Social Services at no cost to general public or to Medicaid patient.]</p> <p>Not provided.</p>
<b>13. Prescribed Drugs</b>	<p>Provided. Legend and non-legend drugs. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charge. Claims processed and paid by State Department of Public Health and Social Services.</p> <p>[In Guam, prescribed drugs are usually obtained by patients from the Guam Memorial Hospital, or from an outpatient facility of the Department of Public Health, with payment being made to the facility from title XIX funds. However, recipients may, if they choose, have prescriptions filled by an independent pharmacist, of which there are several on the Island.]</p>
<b>14. Prosthetic Devices</b>  <b>a. Eyeglasses</b>   <b>b. Hearing Aids</b>   <b>c. Dentures</b>   <b>d. Other Prosthetic Devices</b>	<p>Provided. No limitations. Prior authorization required from State office. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Health and Social Services.</p> <p>Provided. No limitations. Prior authorization required from State office. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Health and Social Services.</p> <p>Not provided.</p> <p>Provided. Limited to persons age 65 or older included in State's buy-in agreement. Devices to replace all or part of an internal organ, and other devices available as benefits under Part B of Medicare. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Health and Social Services.</p>
<b>15. Family Planning Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Health and Social Services.</p>
<b>16. Services of Christian Science Nurses</b>	<p>Not provided.</p>
<b>17. Care and Services in Christian Science Sanatoria</b>	<p>Not provided.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Not provided.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. In cases of emergency or on certification of physician as a medical necessity. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Health and Social Services.
<b>b. Other</b>	Provided. Other appropriate means of transportation, in cases of emergency or on certification of physician as a medical necessity. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Health and Social Services.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as three months prior to the date of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of a father.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Child in foster home or private institution for whom a public agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</p> <p>(4) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(5) Person who is blind (State definition).</p> <p>(6) Person who is permanently and totally disabled (State definition) and age 18 or older.</p>
<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.

### C. Eligibility for Medical Assistance (Continued)

<p><b>3. Coverage of the Categorically Needy</b></p> <p><b>a. FFP Claimed in Medical and Administrative Costs</b></p> <p><b>b. FFP Claimed in Administrative Costs Only</b></p>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(1) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(2) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(3) All children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part.</p> <p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
<p><b>4. Coverage of the Medically Needy</b></p>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a., above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.</p>
<p><b>5. Financial Criteria</b></p> <p><b>a. For Categorically Needy Persons</b></p> <p><b>b. For Medically Needy Persons</b></p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>(1) <i>Income</i> Annual income which may be retained for basic maintenance needs: \$1500 for one person, \$2500 for family of 2, \$2800 for 3, \$3000 for 4, and \$200 for each additional member of the family unit.</p> <p>(2) <i>Resources</i> Real property may be retained, if used as a home or if producing income to meet current needs, up to combined market value of \$12,000. Personal effects and household furnishings are exempt regardless of value. Liquid assets (including cash surrender value of life insurance) may be held up to a combined value of \$1200 for one person, \$1500 for 2, plus \$150 for each additional member of the family unit. Resources in excess of these amounts disqualify applicant from receiving medical assistance under the program.</p>
<p><b>6. Financial Responsibility of Relatives</b></p>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>7. Identification to Vendors of Persons Eligible</b>	A medical identification card called a "Guam XIX Plan Membership Card" is issued by the State office annually for OAA and other "single" recipients certified as eligible and every six months for each eligible family. Card shows case number, names of each person eligible, individual identification number, birthdate, sex, relationship, and expiration date of the card.
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**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Medicaid Section (medical assistance unit) is headed by a Director (MPH) who is directly responsible to the Administrator, Social Services Division. In addition to the Director, the professional staff of the Section consists of 5 full-time Social Service Workers and a Medical Consultant who is a full-time employee of the Department of Health and Social Services.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is handled directly from the State office.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the State Medical Assistance Advisory Committee. It is composed of 15 members appointed by the chairman of the Comprehensive Health Planning Council (members of the Planning Council and others in the community.) There are 4 ex officio members (Director of Public Health and Social Services; Administrator, Division of Social Services; Director, Vocational Rehabilitation; Administrator, Guam Memorial Hospital). Authority for the Committee is statutory.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all recipients under the title XIX program who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	All medical vendor claims are processed and paid by the State Department of Public Health and Social Services.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Guam as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.00.
<b>2. State/Local Participation</b>	Territorial funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	Territory's share of program costs is derived from appropriations made annually from Territorial General Fund. Unobligated balance reverts to General Funds at end of fiscal year.
<b>4. Deficit Financing</b>	If additional funds are needed before the next appropriation period, the agency may apply to the contingency fund. If deficit financing is necessary, a transfer of appropriation by executive authority is made. This may be made within departmental allocation or elsewhere if necessary.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Social Services

January 1, 1970

HAWAII

**A. General Information**

<b>1. Legal Base</b>	The State's authority for assuming medical care costs is based on Sections 26-14, 346-14, 346-57, and 346-61, Hawaii Revised Statutes 1968.
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1966. Original plan approved by the Federal agency on March 31, 1966.
<b>3. Administrative Responsibility</b>	The Department of Social Services serves as the single State agency with responsibility for administering the program on a Statewide basis through 4 Branch Offices (13 local offices) of the Public Welfare Division.
<b>4. Historical Background</b>	<p>Medical vendor payments were made by the old Territorial Department of Public Welfare beginning in 1943, before Federal financial participation was permissible. In 1951, as a result of Act 129 of the legislature, the method of payment was converted to a group prepayment plan, under contract with the Territorial Department of Health to arrange for medical services through the county governments. Federal financial participation in the per capita payments for public assistance recipients under this arrangement began in July 1, 1952. The contract method continued until the State legislature in 1961 transferred responsibility for medical care of all needy and medically needy persons to the Department of Social Services and authorized the Department to make payments directly to the suppliers of medical goods and services. The change went into effect on July 1, 1961.</p> <p>Also on that date the State began a program of Medical Assistance for the Aged, a Federal-State program for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. Under both programs, all the major medical services were provided, with some limitations on costs. However, physicians' services of a general nature were provided in the counties of Maui, Hawaii, and Kauai only through the State Government Physicians, who were paid a regular stipend from State funds, separately from public assistance payments and without direct relationship to the number of public assistance recipients served. These programs continued until the beginning of the title XIX program.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exception:</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B.3. and B.7.a.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. No limitations. Prior authorization by State office required prior to admission when hospitalization is for purpose of elective or non-emergent surgery; required for all extensions of stay beyond 2 days for tonsil and adenoid operation, 5 days for confinement and normal delivery, or 14 days for other admissions; each extension not to exceed 6 days; no limit on number of extensions. <i>Exception:</i> Requirements for agency approval not applicable to hospital admission or stay of recipient age 65 or older covered by Medicare as approved hospital benefit days. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Social Services.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>2. Outpatient Hospital Services</b>	Provided. No limitations except psychiatric services which are limited to two hours evaluation but no treatment. No requirements for prior authorization. Reimbursements are based on agreed fees which are customarily charged private patients with low income.
<b>3. Other Laboratory and X-ray Services</b>	Provided. Unlimited services for persons age 65 or older covered by State's buy-in agreement; no requirements for prior authorization. Same provisions made for others except prior authorization required for procedures costing more than \$25. Reimbursement on basis of usual and customary charge, but not to exceed Hawaii Medical Association's Relative Value study on a negotiated conversion factor of 5. Claims processed and paid by State Department of Social Services.
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No limitations. No requirements for prior authorization by agency. Reimbursement based on reasonable cost except for two nursing homes for which payment, amount not to exceed reasonable cost, is based on classification of Patient under the Department's point system. Payment made only to nursing homes which have entered into contractual agreement with the State agency. Claims processed and paid by State Department of Social Services.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations except psychiatric services limited to 2 hours of evaluation. Prior authorization required for elective surgery. Reimbursement on basis of usual and customary charge, but not to exceed Hawaii Medical Association's Relative Value Study on a conversion factor of 5. Claims processed and paid by State Department of Social Services.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement; and to such services available as benefits under Medicare-Part B. No requirements for prior authorization. Reimbursement on basis of usual and customary charge approved by Part B Carrier. Claims processed and paid by State Department of Social Services.
<b>b. Optometrists</b>	Provided. Eye examinations, refractions, visual analysis, and related optometric services. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary fees up to maximum fees allowable under fee schedule. Claims processed and paid by State Department of Social Services.
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. As furnished by a home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charge. Claims processed and paid by State Department of Social Services.</p> <p>(b) Services of home health aide. As furnished by a home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charge. Claims processed and paid by State Department of Social Services.</p> <p>(c) Medical and sickroom supplies, equipment, and appliances. Provided. No limitations. Prior authorization from State office required for equipment and appliances. Reimbursement on basis of usual and customary charge. Claims processed and paid by State Department of Social Services.</p>								
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p>								
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charge but not to exceed Hawaii Medical Association's Relative Value Study on a conversion factor of 5. Claims processed and paid by State Department of Social Services.</p>								
<b>11. Dental Services</b>	<p>Provided. Fixed bridgework and orthodontic service excluded. Dental prostheses limited to crowns, space maintainers, partial or full dentures, adjustments and repair. X-rays limited to one set of bitewing during a 6-month period; one full mouth X-ray during a 3 year period (including period bitewing is taken); periapical X-rays on a more frequent basis (7 during a 12-month period) for children under age 10. Preventive dentistry limited to once during a 12-month period. Restorative dentistry limited to use of amalgamate, silicate, or plastic fillings. Prior authorization by State office required for all services except treatment for immediate relief of toothache, emergency dental Surgery for treatment of injury, and where aggregate cost of treatment plan does not exceed \$30; period of authorization for completion of treatment not to exceed 60 days, with extension up to 30 days upon written request of dentist. Reimbursement on basis of usual and customary charges, not to exceed fee schedule of maximum allowances (adopted jointly by Department of Health, and Department of Social Services). Vendor payments made to dentists on behalf of recipients who are enrolled under Hawaii Dental Service Plan (prepaid group dental,health plan) and who are unable to meet the required co-payments. Claims processed and paid by State Department of Social Services.</p>								
<b>12. Physical Therapy and Related Services</b>	<table> <tr> <td data-bbox="70 1297 438 1507"> <b>a. Physical Therapy</b> </td><td data-bbox="438 1297 1516 1507"> <p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p> </td></tr> <tr> <td data-bbox="70 1507 438 1633"> <b>b. Occupational Therapy</b> </td><td data-bbox="438 1507 1516 1633"> <p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p> </td></tr> <tr> <td data-bbox="70 1633 438 1759"> <b>c. Speech Therapy</b> </td><td data-bbox="438 1633 1516 1759"> <p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p> </td></tr> <tr> <td data-bbox="70 1759 438 1848"> <b>d. Audiology</b> </td><td data-bbox="438 1759 1516 1848"> <p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p> </td></tr> </table>	<b>a. Physical Therapy</b>	<p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p>	<b>b. Occupational Therapy</b>	<p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p>	<b>c. Speech Therapy</b>	<p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p>	<b>d. Audiology</b>	<p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p>
<b>a. Physical Therapy</b>	<p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p>								
<b>b. Occupational Therapy</b>	<p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p>								
<b>c. Speech Therapy</b>	<p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p>								
<b>d. Audiology</b>	<p>Provided. As furnished by home health agency or other qualified provider. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.</p>								



**B. Medical and Remedial Care and Services (Continued)**

<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs, on written prescription of physician or dentist. Refills not permitted except contraceptive drugs for three cycles. No requirements for prior authorization. Reimbursement on basis of usual and customary charges which are reasonable. Claims processed and paid by State Department of Social Services.
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Provided. Contact lenses excluded. No other limitations. Reimbursement on basis of maximum allowable fee schedule. Payment made to ophthalmologists, optometrists, opticians, and dispensing firms. Claims processed and paid by State Department of Social Services.
b. Hearing Aids	Provided. Prior authorization required except for repairs and battery replacements. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.
c. Dentures	Provided. No limitations. Prior authorization by State office required when cost exceeds \$30. Reimbursement on basis of usual and customary charge, but not to exceed fee schedule of maximum allowances. Claims processed and paid by State Department of Social Services.
d. Other Prosthetic Devices	Provided. Including back and leg braces, orthopedic shoes and pacemaker. Prior authorization required when cost exceeds \$25. Reimbursement on basis of usual and customary charge. Claims processed and paid by State Department of Social Services.
<b>15. Family Planning Services</b>	Provided. Including contraceptive drugs and services, sterilization, fertility tests, and correction of infertility. No limitations. Prior authorization by State office required for tuboplasty. Reimbursement to physician on basis of usual and customary charge, but not to exceed Hawaii Medical Association's Relative Value Study on a conversion factor of 5. Reimbursement to pharmacy on basis of usual and customary charges. Claims processed and paid by State Department of Social Services.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Not provided.  [All hospitals in Hawaii are Medicare-certified.]
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. Immunizations and vaccinations; physical examinations for specified purposes (e.g., school health clearance, premarital examinations, pre-employment physicals, pre-admission and annual examinations for care homes); routine laboratory tests to complete physicals; as well as diagnostic screening. Prior authorization by State office not required. Reimbursement on basis of usual and customary charge, but not to exceed Hawaii Medical Association's Relative Value Study on a conversion factor of 5. Claims processed and paid by State Department of Social Services.
<b>21. Transportation</b>	
a. Ambulance	Provided. To or between medical facilities, when other forms of transportation would cause hardship or be injurious to recipient. No limitations. No requirement for prior authorization. Reimbursement on basis of usual and customary charge (zone rates). Claims processed and paid by State Department of Social Services.

## B. Medical and Remedial Care and Services (Continued)

<b>b. Other</b>	Provided. When medically necessary. By licensed taxis, buses, and (when necessary care is available only in another county) scheduled airlines. Including transportation cost of attendant, if recommended by physician or required by airlines office. No limitations. No requirements for prior authorization. Reimbursement on basis of fixed rate. Claims processed and paid by State Department of Social Services.
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## C. Eligibility for Medical Assistance

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as 60 days prior to date of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under age 21</b>	<ul style="list-style-type: none"> <li>(1) Child under age 21. (This group does not include an individual under age 21 who is emancipated by marriage or other provision of State law.)</li> <li>(2) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of parent; or unemployment of father.</li> <li>(3) Person who is blind (State definition).</li> <li>(4) Person who is permanently and totally disabled (State definition) and age 18 or older.</li> <li>(5) Essential spouse [title XIX definition] of a recipient of AABD.</li> </ul>
<b>b. Age 21 to 64</b>	<ul style="list-style-type: none"> <li>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</li> <li>(2) Person who is blind (State definition).</li> <li>(3) Person who is permanently and totally disabled (State definition).</li> <li>(4) Essential spouse [title XIX definition] of a recipient of AABD.</li> </ul>
<b>c. Age 65 or older</b>	<ul style="list-style-type: none"> <li>(1) Individual who has attained age 65.</li> </ul>
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <ul style="list-style-type: none"> <li>(1) Recipients of AABD and AFDC.</li> <li>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</li> <li>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</li> </ul> <p style="text-align: center;"><i>Optional</i></p> <ul style="list-style-type: none"> <li>(4) Persons eligible for but not receiving AABD or AFDC.</li> <li>(5) Persons in a medical facility (not including an institution for tuberculosis or mental diseases) who are not recipients of financial assistance under the State's AABD or AFDC programs but who would be eligible for such assistance if they left the facility.</li> <li>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</li> <li>(7) All children under age 21.</li> <li>(8) Essential spouse [title XIX definition] of a recipient of AABD. (Categorically needy only)</li> </ul>



## C. Eligibility for Medical Assistance (Continued)

	<i>Optional</i>
b. FFP Claimed in Administrative Costs Only	(1) Persons age 21 or older receiving financial assistance under the State's General Assistance program.
4. Coverage of the Medically Needy	Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Items C.3.a. (1) through (7), and C.3.b., above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.
5. Financial Criteria	The following criteria are used in establishing financial eligibility for medical assistance:
a. For Medically Needy Persons	<p>(1) <i>Income</i> Annual income which may be retained for basic maintenance needs: \$1560 for one person, \$2580 for family of 2, \$2940 for 3, \$3480 for 4, \$4020 for 5, \$4500 for 6, \$5160 for 7, and \$480 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$7.50 per month (\$90 per year) for personal expenses. Additional income may be applied to maintenance needs of dependents up to \$1560 per year for one dependent, \$2580 for 2 dependents, and higher amounts for additional dependents (according to progression stated in preceding paragraph).</p> <p>(2) <i>Resources</i> Real property used as a home may be retained up to a tax-appraised value of \$25,000; other real property up to a tax-appraised value of \$225.</p> <p>The following property in its entirety is considered available to meet the costs of medical care: Cash value of life insurance; stocks and bonds if currently registered on an exchange; cash and other savings (e.g., bank accounts, building and loan accounts, credit union accounts, accounts or deposits available in cash on demand or within 30 days).</p> <p>An automobile more than 4 years old is not considered a resource. If less than 4 years old, it is exempt (1) if needed for transportation in remote areas where other means of transportation are inadequate, or in other areas if used for employment, marketing, school or vocational training attendance, or to obtain medical care, or (2) if sale at current market value less encumbrances will not produce more than \$400.</p> <p>The following personal property is exempt regardless of value: Household goods and personal effects (e.g., household appliances, radios, pianos, television, furniture, jewelry, and clothing).</p> <p>Property exceeding these limitations must be sold or used to produce income. Unless a plan to take such action within an acceptable period of time is made and approved by the local welfare office, applicant is ineligible to receive medical assistance.</p>
6. Financial Responsibility of Relatives	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 20.
7. Identification to Vendors of Persons Eligible	An "Identification Card for Medical Services" is issued to each money payment recipient and family on a month-to-month basis, and is valid until the next date of issuance. Identification card for the medically needy is issued and made valid up to the next eligibility review date. Duration depends on the category to which basic eligibility is related. Face of card shows case name as well as the case number, public assistance category, and name of local office. Medically needy cases with excess income to be applied to costs of care are identified on the card as "Conditional approval only". For such cases, contact is made and an understanding reached between vendor and agency as to portion of the claim for which agency will not be responsible.



**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Administrator (profession of medical administration) of the Medical Care Administration Service (medical assistance unit) is directly responsible to the Public Welfare Administrator within the Department of Social Services. Full-time professional staff of the Unit serving under his direction consists of a Medical Consultant (M.D.), a Medical Welfare Specialist (social worker), Psychiatric Social Work Consultant (social worker) and Nursing Consultant (registered professional nurse). This staff is supplemented by the part-time services of a Pharmaceutical Consultant (registered pharmacist) and a Dental Consultant (D.D.S.).
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operation is accomplished through the office of the Public Welfare Administrator with consultation provided by staff of the medical assistance unit. In addition, in Honolulu there is a medical assistance unit consisting of 10 social workers (full-time) and a social work supervisor. Medical Consultant of the State medical assistance unit also serves in a similar capacity to the Honolulu local office.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Care Advisory Committee. It is composed of 15 members appointed by the Director of the Department of Social Services. There are 3 ex officio members: (Director of the Department of Social Services, the Public Welfare Administrator, and the Medical Care Administrator). Authority for the Committee is administrative.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all the XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	All claims for Medical care and services are processed and paid by the State Department of Social Services.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Hawaii as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.75.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	An appropriation is made annually for the Department of Social Services by the State Legislature which specifies sub-amounts for line item "Payment to Indigents and Medically Indigent". Before the Department expends any amount of an appropriation, a quarterly allotment must be authorized by the Department of Budget and Finance. Transfer of funds between program appropriations within the Department may be made upon certification by the Director of the Department and approval by the State Director of Budget and Finance, if necessary to accomplish program objectives authorized by the Legislature. If appropriated funds are insufficient to cover urgent needs, relief may be sought through the Governor's Contingency Fund, for which the State Legislature makes a lump sum appropriation annually.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. Availability and expenditure of State funds are limited to those amounts necessary to provide the level of services intended by the Legislature based on population and workload data specified in the Appropriation Act. If the trend is higher than specified figures, the Department is authorized to submit a deficit appropriation request.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Assistance

January 1, 1970

IDAHO

**A. General Information**

<b>1. Legal Base</b>	Title 56, Chapter 2, Idaho Code, as amended. (Specific implementing legislation was enacted: Chapter 11, Laws 1966, Second Special Session.)
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on June 28, 1966.
<b>3. Administrative Responsibility</b>	The Department of Public Assistance serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices (28).
<b>4. Historical Background</b>	Provisions for vendor payments for the costs of medical care for recipients of OAA, AB, and APTD began January 1, 1959, for care in nursing homes. In 1960, the State added the following services for OAA: Inpatient hospital care, services of physicians and surgeons, X-ray and laboratory work, and drugs listed in the formulary of the Department of Public Assistance. Legislation in 1961 eliminated all of these services except inpatient hospital care and services of physicians and surgeons. The same Act authorized a program of Medical Assistance for the Aged (a Federal-State program for persons age 65 and older who were not recipients of public assistance but met certain criteria of financial and medical need), effective July 1, 1961. This program provided for inpatient hospital care and the services of "medical doctor, osteopath, chiropractor, optometrist, and podiatrist." It also provided for nursing home care for all eligible persons age 65 and older, including recipients of OAA. During these years up to July 1966, only nursing home care was provided for recipients of AB and APTD and no provision was made for vendor payments for medical care for AFDC.
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C. 3.)
<b>6. Differences in Scope of Services Provided</b>	Medical assistance made available under the program is equal in amount, duration, and scope for all individuals with the following exceptions:  Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B. 4.)  Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B. 8. (a), (b), and (c); B. 10; B. 12. a., b., and c.; B. 14. d.; B. 21. a.)

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. Limited to 20 days per admission. Semi-private accommodations only. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Assistance.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary fees but not to exceed reasonable cost (according to title XVIII standards and principles). Claims processed and paid by State Department of Public Assistance.



**B. Medical and Remedial Care and Services (Continued)**

<b>3. Other Laboratory and X-ray Services</b>	Provided. In independent laboratories headed by a physician. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary fees, but not to exceed reasonable cost (according to title XVIII standards and principles). Claims processed and paid by State Department of Public Assistance.
<b>4. Skilled Nursing Home Services</b>	
a. General	Provided. Limited to persons age 21 or older. No other limitations. No requirement for authorization prior to admission, but nursing home must notify local office within 12 hours (if possible) of patient's admission; subsequent authorization by local office required for payment. Reimbursement on basis of negotiated monthly rate for each nursing home, based on financial reports submitted by the home at least annually. Monthly rate not to exceed reasonable cost determined applicable for the facility under title XVIII. Claims processed and paid by State Department of Public Assistance.
b. In Institutions for Tuberculosis	Not provided.
c. In Institutions for Mental Diseases	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary fees, but not to exceed prevailing charges in the locality for comparable services under comparable conditions. (North and South Idaho Service Bureau fee schedules used as a guide in determining reasonable charges.) Claims processed and paid by State Department of Public Assistance.
<b>7. Services of Licensed Practitioners</b>	
a. Podiatrists	Provided. Limited to treatment of acute foot conditions. No requirements for prior authorization. Reimbursement on basis of usual and customary fees, but not to exceed prevailing charges in the locality for comparable services under comparable conditions. Claims processed and paid by State Department of Public Assistance.
b. Optometrists	Provided. Eye examinations for purpose of determining visual acuity limited to one during any 12-month period. No requirements for prior authorization. Reimbursement on basis of usual and customary fees, but not to exceed prevailing charges in the locality for comparable services under comparable conditions. (Maximum fee of \$18 for complete eye examination considered reasonable.) Claims processed and paid by State Department of Public Assistance.
c. Chiropractors	Provided. Limited to 3 office visits during any calendar month. No requirements for prior authorization. Reimbursement on basis of usual and customary fees, but not to exceed prevailing charges in the locality for comparable services under comparable conditions. (Maximum fee of \$7 for an office visit considered reasonable.) Claims processed and paid by State Department of Public Assistance.
d. Other	Not provided.
<b>8. Home Health Care Services</b>	Not provided.
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided



**B. Medical and Remedial Care and Services (Continued)**

<b>10. Clinic Services (Other than Hospital)</b>	Not provided.
<b>11. Dental Services</b>	Not provided.
<b>12. Physical Therapy and Related Services</b>	
a. Physical Therapy	Not provided.
b. Occupational Therapy	Not provided.
c. Speech Therapy	Not provided.
d. Audiology	Not provided
<b>13. Prescribed Drugs</b>	Not provided.
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Not provided.
b. Hearing Aids	Not provided.
c. Dentures	Not provided.
d. Other Prosthetic Devices	Provided. For recipients under all public assistance categories. Devices to replace all or part of an internal organ, and other devices. No requirements for prior authorization. Reimbursement on basis of reasonable charges. Claims processed and paid by State Department of Public Assistance.
<b>15. Family Planning Services</b>	Provided. Limited to physician's services. No requirements for prior authorization. Reimbursement on basis of usual and customary fees. Claims processed and paid by State Department of Public Assistance.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospi- tal not qualified under title XVIII or State's title XIX program).</b>	Provided. Limited to 20 days per admission. No requirements for prior authorization. Reimbursement on basis of usual and customary fees. Claims processed and paid by State Department of Public Assistance.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
a. Ambulance	Not provided.
b. Other	Not provided.

### C. Eligibility for Medical Assistance

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as three months prior to the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C. 3. a.:
<b>a. Under Age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p>
<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p>
<b>b. FFP Claimed in Administrative Costs Only</b>	<i>Optional</i> None.
<b>4. Coverage of the Medically Needy</b>	Not included.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.

**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	Not applicable.
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.
<b>7. Identification to Vendors of Persons Eligible</b>	A perforated stub labeled "Identification for Medical Assistance" is attached to each monthly assistance check. Individuals approved for medical assistance without a money payment also receive the monthly stub, attached to a blank check form. The card (i.e., stub) lists the names of all eligible persons in the household group, patient numbers, category or program, and case number. Cards are mailed from the State office and are valid only for the month for which issued.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Bureau of Medical Assistance (the medical assistance unit) is headed by a Director (M.A. in Social Work) who is responsible to the Deputy Commissioner for Program Operations. The full-time professional staff consists of a Medical Consultant (M.D.) Medical Social Consultant, and Nursing Care Consultant. [The position of Medical Social Consultant was vacant as of January 1, 1970.]
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the regular field staff of the Department of Public Assistance.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Assistance Advisory Committee. It is composed of 11 members appointed by the Governor. Authority for the Committee is administrative.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Public Assistance processes and pays all medical vendor claims for medical assistance provided under the program.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Idaho as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 68.91.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially. Unexpended balance may be carried over to the next biennium.
<b>4. Deficit Financing</b>	State Constitution prohibits deficit financing. If additional funds are needed before the next appropriation period, the program must be curtailed or a special session of the State Legislature must be called to appropriate additional funds.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Aid

January 1, 1970

ILLINOIS

**A. General Information**

<b>1. Legal Base</b>	Article VII-B of the Public Assistance Code (added to Illinois Revised Statutes, Chapter 23, by H.B. No. 1708, 74th Illinois General Assembly, 1965 Regular Session).
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1966. Original plan approved by the Federal agency on March 31, 1966.
<b>3. Administrative Responsibility</b>	The Department of Public Aid is the single State agency with responsibility for administration of the program on a Statewide basis through 102 county departments of public aid.
<b>4. Historical Background</b>	Illinois has provided medical care to public assistance recipients through the vendor payment method since 1952. From August 1953 to October 1965, payments were made through a pooled fund; since then, through a trust fund devoted exclusively to medical payments. Prior to adoption of the Medical Assistance program under title XIX, a comprehensive range of medical services was available to recipients of AABD and AFDC, representing full implementation of the agency's statutory authority. In August 1961, on the basis of newly enacted legislation, a program of Medical Assistance for the Aged (MAA) was instituted providing medical care for persons age 65 or older who were not recipients of public assistance but who met certain prescribed conditions of financial and medical need. Although the MAA legislation would have permitted a comprehensive medical program, limitations on appropriations resulted in substantial limitations.
<b>5. Scope of Coverage</b>	Program provides for coverage of both categorically and medically needy persons. (See Items C.3. and C.4., below).
<b>6. Differences in Scope of Services Provided</b>	Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exception:  Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Item B.1.b. and c.; B.4.b. and c.)

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims for persons age 65 or older processed and Medicare deductible and coinsurance paid by fiscal agent (Hospital Service Corporation); all other claims processed by State Department of Public Aid; all other reimbursable amounts paid by State Auditor of Public Accounts.
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older in public (State, county, or municipal) institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of established per diem rate. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older in State mental hospitals. No other limitations. No requirements for prior authorization. Reimbursement on basis of cost of medical and other treatment services rendered. Claims processed by State Department of Public Aid.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reimbursable cost most recently reported to the Department of Public Health, which includes the professional component charge. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.

**B. Medical and Remedial Care and Services (Continued)**

<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For persons of all ages. No limitations. Prior authorization required from county department of public aid. Reimbursement on basis of rate schedule with point system related to kind and amount of care required by individual recipient. Claims for persons age 65 or older processed and Medicare coinsurance paid by fiscal agent (Hospital Service Corporation, <i>or</i> Aetna Life Insurance Co.); all other claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.</p> <p>Provided. Limited to persons age 65 or older in public (State, county, or municipal) institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of established per diem rate. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.</p> <p>Provided. Limited to persons age 65 or older in State mental hospitals. No other limitations. No requirements for prior authorization. Reimbursement on basis of cost of medical and other treatment services rendered. Claims processed by State Department of Public Aid.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Not provided.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charge if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>  <b>b. Optometrists</b>  <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Provided. Limited to specified non-routine services. No requirements for prior authorization. Reimbursement on basis of usual and customary charge, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.</p> <p>Provided. Limited to eye examinations and optical goods. No requirements for prior authorization. Reimbursement on basis of usual and customary charge, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided if prescribed by physician and furnished by home health agency or private-practicing RN or LPN. No limitations. Extensions beyond 30 days require prior authorization. Reimbursement of home health agency on basis of cost or charge per visit, whichever is lower; of RN or LPN, on basis of fixed fee per visit. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.</p> <p>(b) Services of home health aide. Provided if part of certified Home Health Agency services.</p> <p>(c) Medical supplies, equipment and appliances. Provided, when prescribed by physician. Prior authorization required. Reimbursement on basis of reasonable charge. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Provided. In patient's home and in hospital, if prescribed by physician. Prior authorization of local department of public aid required. Reimbursement for services to hospital inpatient on basis of usual and customary charge; in patient's home, on time basis at the going rate in the community. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.</p>



**B. Medical and Remedical Care and Services (Continued)**

<b>10. Clinic Services (Other than Hospital)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charge, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>11. Dental Services</b>	Provided. No limitations, except that orthodontia is limited to cases which present a handicapping malocclusion or handicapping dento-facial deformity. Orthodontia and specified dental procedures require prior authorization from State Department of Public Aid. Reimbursement on basis of usual and customary charges, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. Prior authorization of local department of public aid required. Reimbursement on basis of usual and customary charges, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>b. Occupational     Therapy</b>	Provided. Prior authorization of local department of public aid required. Reimbursement on basis of usual and customary charges, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>c. Speech Therapy</b>	Provided. Prior authorization of local department of public aid required. Reimbursement on basis of usual and customary charges, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>d. Audiology</b>	Provided. No limitations. Prior authorization of local department of public aid required. Reimbursement on basis of usual and customary charges, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs, as listed in drug formulary. All drugs provided to hospital inpatients, regardless of formulary; for other recipients, prior authorization by State Department of Public Aid required for drugs not on formulary list. Prescriptions limited to original and two refills. Reimbursement on basis of fee schedule or prices charged to general public, whichever is lower. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. No limitations, but must be prescribed by physician or optometrist. Prior authorization by State Department of Public Aid required for special lenses and frames. Payment to physicians, optometrists and opticians. Reimbursement on basis of cost plus specified percentage. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>b. Hearing Aids</b>	Provided. No limitations. Prior authorization by State Department of Public Aid required, based on medical reports and benefits to be derived. Reimbursement on basis of reasonable charge. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>c. Dentures</b>	Provided. Limited to cases where masticatory deficiencies are likely to impair general health. Prior authorization by State Department of Public Aid required. Reimbursement based on usual and customary charges, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>d. Other Prosthetic     Devices</b>	Artificial limbs. Provided, if recommended by amputee clinic, rehabilitation facility, or specialist. Prior authorization by State Department of Public Aid required. Reimbursement on basis of usual and customary charges. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>15. Family Planning Services</b>	Provided. No limitations. No requirements for prior authorization. Payments to physicians and organized facilities. Reimbursement on basis of usual and customary charges, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.



**B. Medical and Remedial Care and Services (Continued)**

<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. Facility must be certified as skilled nursing home by Department of Public Health.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Not provided.
<b>19. Personal Care Services in Patient's Home</b>	Provided. No limitations. Prior authorization by county department of public aid required. Reimbursement on basis of negotiated rate. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	<i>Diagnostic services:</i> without limitations or requirements for prior authorization. <i>Preventive services:</i> limited to physical and dental examination and immunization: for all school children; no requirements for prior authorization. <i>Rehabilitative services:</i> if recommended by physician; prior authorization by local department of public aid. Reimbursement on basis of usual and customary charges, if reasonable. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. No limitations. Prior authorization by county department of public aid required except in emergencies. Reimbursement on basis of going rate in the community. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.
<b>b. Other</b>	Provided. Transportation by any appropriate means, including other travel expenses. No limitations. Prior authorization by county department of public aid required. Reimbursement on basis of going rate in the community. Claims processed by State Department of Public Aid; paid by State Auditor of Public Accounts.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Individuals meeting conditions of eligibility are entitled to medical assistance under the program for services beginning with the first day of the month prior to the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.
<b>a. Under Age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(3) Child in foster home or private institution for whom public child welfare agency is assuming financial responsibility. (Including non-AFDC foster care.)</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition), and age 18 or older.</p>
<b>b. Age 21 to 64</b>	<p>(1) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>

## C. Eligibility for Medical Assistance (Continued)

c. Age 65 or older	(1) Individual who has attained age 65.
3. Coverage of the Categorically Needy	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
a. FFP Claimed in Medical and Administrative Costs	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of AABD and AFDC.  (2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.  (3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving AABD or AFDC.  (5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC program but who would be eligible for such assistance if they left the facility.  (6) Caretaker relatives (as specified in the State's AFDC plan) with whom dependent children described in Item C.3.a. (3), above, are living.  (7) Children under age 21 in foster homes or private child welfare institutions for whom public child welfare agencies are assuming financial responsibility.</p>
b. FFP Claimed in Administrative Costs Only	(1) Families eligible under the State's AFDC-UP (Unemployed Parent) program which are not eligible under the more restrictive provisions of the Social Security Act, i.e., where eligibility is based on mother's unemployment or on father's unemployment for less than 30 days, and in cases of supplementation of unemployment compensation.
4. Coverage of the Medically Needy	Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Items C.3.a. and b. above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with regulations.
5. Financial Criteria	The following criteria are used in establishing financial eligibility for medical assistance:
a. For categorically Needy Persons	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
b. For Medically Needy Persons	<p>(1) <i>Income</i>  Net annual income (defined as gross income less income taxes, social security deductions, and union dues, if any) which may be retained for basic maintenance needs: \$1800 for one person, \$2400 for 2 persons, \$3000 for 3 persons, \$3600 for 4 persons, plus \$600 for each additional person.</p> <p>(2) <i>Resources</i>  Homestead may be retained regardless of value or equity. ("Homestead" defined as home and contiguous real estate owned and occupied by applicant or recipient). Other real property, if saleable, may not be retained.</p> <p>Other resources may be retained up to a value of \$400 for the first person, \$200 for the second person, and \$100 for each additional person. The following property is not taken into consideration in determining these resources: Household furnishings, personal effects, one "essential" automobile, and tools or other equipment used in producing income.</p> <p>Resources in excess of these amounts do not render an individual ineligible, but the excess must be applied to costs of medical care.</p>



**C. Eligibility for Medical Assistance (Continued)**

<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children under age 21.
<b>7. Identification to Vendors of Persons Eligible</b>	An Identification Card is issued to each one-person or multiple-person case certified as eligible. Card shows expiration date.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	Responsibility for over-all direction of the Medical Assistance program is vested in the Division of Medical Services, one of the primary organizational segments under the Director of the State Department of Public Aid. Principal professional and executive staff of the Division consists of a Director (M.D.), a Chief, Medical Administration, 3 Supervisors (Medical Program Development, Medical and Institutional Services, and Medical Payments Section), a pharmacist, 4 medical assistance consultants, and 6 social workers. The services of 11 physicians, a dentist, a podiatrist, and an optometrist are also available on a part-time basis.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operation of the program is maintained through the activities (full-time) of 4 supervisory and 6 consultative staff members operating at-large, and of 6 consultative staff members assigned to specific geographical areas.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Care Advisory Committee. It is composed of 12 members appointed by the Director, State Department of Public Aid, and has in addition 5 ex officio members (Directors of the Departments of Mental Health, Public Health, and Children and Family Services, and the Directors of the Division of Vocational Rehabilitation and of Services for Crippled Children). Total membership may be changed, at discretion of the Director. Authority for the Committee is administrative.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under both title XVIII of the Social Security Act and the State's title XIX program.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Public Aid processes, and the State Auditor of Public Accounts pays, all vendor claims for services provided to recipients with the exception of claims for services to patients age 65 or older in general hospitals and extended care facilities, which are processed and paid by fiscal agents.
<b>b. Fiscal Agents</b>	<p>The State Department of Public Aid has entered into two fiscal agent contracts for the processing and payment of certain claims for services provided to recipients age 65 or older.</p> <p>(1) Contract with Hospital Service Corporation (Blue Cross). Provides that fiscal agent shall process and pay all claims for inpatient hospital services provided to eligible persons age 65 or older and claims for such persons provided by extended care facilities which have nominated that corporation as their Medicare intermediary.</p> <p>(2) Contract with Aetna Life Insurance Company. Provides that fiscal agent shall process and pay all claims for services provided to persons age 65 or older by extended care facilities which have nominated that company as their Medicare intermediary.</p>
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.



**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Illinois as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.00.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from State General Funds appropriated annually. Unobligated balance may be carried over to the next fiscal year.
<b>4. Deficit Financing</b>	When additional funds are needed before the next appropriation period, a deficiency appropriation may be made by the General Assembly and approved by the Governor.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SECURITY SOCIAL ACT

Department of Public Welfare

January 1, 1970

INDIANA

**A. General Information**

<b>1. Legal Base</b>	Chapter 274, Acts of 1969, General Assembly of the State of Indiana.
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1970. Original plan approved by the Federal agency on December 31, 1969.
<b>3. Administrative Responsibility</b>	The Department of Public Welfare serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices (92 county departments of public welfare).
<b>4. Historical Background</b>	Provisions for meeting the cost of medical care as part of the public assistance program with Federal financial participation have been in effect since October 1, 1950 for OAA, AB, and AFDC and since January 1963 for APTD. The plans varied among the counties as to whether a given service was paid for by vendor payments to suppliers of medical care and services or by provision in the money payment to the recipient. The State maximums on the money payment for total assistance needs could be exceeded "to meet necessary medical expenses." From January 1965 through December 1969, the State also maintained a Federal-State program of Medical Assistance for the Aged, i.e., payments to suppliers of medical care in behalf of persons age 65 and over who were not recipients of public assistance but met certain criteria of financial and medical need. The services provided under all programs included those for "chronic and acute illnesses as well as services for prevention and rehabilitation."
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C. 3.)
<b>6. Differences in Scope of Services Provided</b>	Medical assistance made available to categorically needy persons is equal in amount, duration, and scope for all individuals with the following exception:  Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B. 5) [Similar services are provided to persons over the age of 21. See Item B. 20.]

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. No limitations. No requirements for prior authorization but continuation of stay is controlled by physician's recommendation and utilization review. Reimbursement on basis of reasonable cost according to standards, periods, principles, and methods of cost apportionment currently used in computing reimbursement to hospitals under Title XVIII of the Act. Claims processed and paid by fiscal agent (Mutual Hospital Insurance, Inc.)
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on a basis not to exceed the combined payments received by providers (for furnishing comparable services under comparable circumstances) from the intermediaries or carriers under Title XVIII and the beneficiary under Title XVIII of the Social Security Act. Claims processed and paid by the fiscal agent (Mutual Hospital Insurance, Inc.)



**B. Medical and Remedial Care and Services (Continued)**

<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on a basis not to exceed the combined payments received by providers (for furnishing comparable services under comparable circumstances) from the intermediaries or carriers under Title XVIII and the beneficiary under Title XVIII of the Social Security Act. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost on a facility by facility basis not to exceed the combined payments received by providers for furnishing comparable services under comparable circumstances from the intermediary or carriers under Title XVIII and beneficiary under Title XVIII of the Social Security Act. Vendors required to accept payment from "Third Parties" (e.g. responsible relatives, any other available income source) when available and up to the specified dollar maximum rate recognized by the state agency as appropriate for the level of care provided to supplement state payment. Claims processed and paid by fiscal agent (Mutual Hospital Insurance, Inc.).
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges not to exceed the 75th percentile of those charges effective January 1, 1969. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Services rendered within the scope of his practice as defined by state law to include diagnosis or mechanical, medical, or surgical treatment. Excluded are treatment of flat foot conditions, subluxations, routine palliative or hygienic care, except as these treatments may be medically necessary and prior approval of the procedure obtained from the fiscal agent. Reimbursement on basis of usual and customary charges not to exceed the 75th percentile of those charges effective January 1, 1969. Claims processed and paid by fiscal agent. (Mutual Medical Insurance, Inc.).
<b>b. Optometrists</b>	Provided. No limitations. Prior authorization required from local office for eyeglasses. Reimbursement for professional services of dispensing optometrist on the basis of usual and customary fees not to exceed the 75th percentile of those fees effective January 1, 1969. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
<b>c. Chiropractors</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges not to exceed the 75th percentile of those charges effective January 1, 1969. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time services. Provided. When furnished by certified home health agency. Unlimited number of visits. No requirements for prior authorization. Reimbursement on basis of established rate for agency providing the service. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>(b) Services of home health aide. Provided. When furnished by certified home health agency. Unlimited number of visits. No requirements for prior authorization. Reimbursement on basis of established rate for agency providing the service. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations, but must be medically necessary and prescribed by a physician. Prior authorization from local office required. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Provided. No limitations. No requirements for prior authorization but must be prescribed by physician. Reimbursement on basis of going rate for nursing service in area. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on a basis not to exceed the combined payments received by providers (for furnishing comparable services under comparable circumstances) from the intermediaries or carriers under title XVIII and the beneficiary under title XVIII of the Social Security Act. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p>
<b>11. Dental Services</b>	<p>Provided. Preventive and emergency dentistry. Topical application of fluoride provided only for patients age 16 or younger, and limited to one application a year. Endodontics, orthodontics, periodontics, and prosthodontics for medical reasons require prior authorization by fiscal agent; when aforementioned procedure is necessary to make individual employable, prior authorization supplied by local agency. Reimbursement on basis of usual and customary charges not to exceed 75th percentile of those charges effective January 1, 1969. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p>
<b>12. Physical Therapy and Related Services</b>  <b>a. Physical Therapy</b>  <b>b. Occupational Therapy</b>  <b>c. Speech Therapy</b>  <b>d. Audiology</b>	<p>Provided. No limitations. No requirements for prior authorization, but must be on physician's continuing prescription. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p> <p>Provided. In clinic or hospital setting. In addition, for persons age 65 or older covered by State's buy-in agreement, as furnished by a certified home health agency (within maximum limit of 100 visits per year for all home health agency visits). No requirements for prior authorization. Reimbursement on a basis not to exceed the combined payments received by providers (for furnishing comparable services under comparable circumstances) from the intermediaries or carriers under title XVIII and the beneficiary under title XVIII of the Social Security Act. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p> <p>Provided. As furnished by clinic or hospital. In addition, for persons age 65 or older covered by State's buy-in agreement, as furnished by a certified home health agency (within maximum limit of 100 visits per year for all home health agency visits). No requirements for prior authorization, but service must be provided on physician's prescription. Reimbursement on a basis not to exceed the combined payments received by providers for furnishing comparable services under comparable circumstances) from the intermediaries or carriers under title XVIII and the beneficiary under title XVIII of the Social Security Act. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p> <p>Provided. No limitations, but must be prescribed by physician. Prior authorization from local office required. Reimbursement on a basis not to exceed the combined payments received by providers (for furnishing comparable services under comparable circumstances) from the intermediaries or carriers under title XVIII and the beneficiary under title XVIII of the Social Security Act. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p>
<b>13. Prescribed Drugs</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of acquisition cost plus professional fee (\$1.85 per prescription). Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Provided. No limitations. Prior authorization by local office required for initial service and for any item costing in excess of \$20. Reimbursement on basis of set fee and reasonable charge structure. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
b. Hearing Aids	Provided. No limitations. Physician's recommendation and prior authorization by local office required. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
c. Dentures	Provided. No limitations. Prior authorization by local office required for some types of dental structures. Reimbursement on basis of usual and customary charges not to exceed the 75th percentile of those charges effective January 1, 1969. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
d. Other Prosthetic Devices	Provided. No limitations, but must be prescribed by a physician. Prior authorization from local office is required. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
<b>15. Family Planning Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
<b>16. Services of Christian Science Nurses</b>	Provided. No limitations. Policy regarding prior authorization requirements not yet developed. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. In Christian Science Sanatoria which sign a provider agreement with the Department. No requirements for prior authorization but services must be recommended by a Christian Science Practitioner as listed in the <i>Christian Science Journal</i> . Reimbursement on basis of reasonable cost on a facility by facility basis not to exceed the combined payments received by providers for furnishing comparable services under comparable circumstances from the intermediary or carriers under title XVIII and beneficiary under title XVIII of the Social Security Act. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. For period necessary until patient can be moved to a qualified hospital without danger to life or impairment of health. No requirements for prior authorization. Reimbursement on basis of reasonable cost (Medicare emergency basis). Claims processed and paid by fiscal agent (Blue Cross Hospital Service).
<b>19. Personal Care Services In Patient's Home</b>	Provided. When recommended by physician and supervised by registered nurse. Monthly cost must not exceed care in a skilled nursing home. Prior authorization by local office and State Department of Public Welfare required. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided.  [Included in State plan, but details of services to be provided have not yet been defined.]
<b>21. Transportation</b>	
a. Ambulance	Provided. No limitations. Prior authorization by local office required except for emergencies or when provided as a Medicare benefit to persons age 65 or older covered by State's buy-in agreement. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).



**B. Medical and Remedial Care and Services (Continued)**

<b>b. Other</b>	Provided. By taxi, train, other common carrier; also by private automobile if properly insured and driver has chauffeur's license. No limitations. Prior authorization by local office required. Reimbursement for private vehicle at rate of 10¢ per mile; for other forms of conveyance on basis of reasonable charges. Claims processed and paid by fiscal agent (Mutual Medical Insurance, Inc.).
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**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C. 3. a.:
<b>a. Under Age 21</b>	<ul style="list-style-type: none"> <li>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</li> <li>(2) Child in AFDC foster care.</li> <li>(3) Child deprived of parental support or care, living with a stepfather.</li> <li>(4) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</li> <li>(5) Person who is blind (State definition) and age 18 or older.</li> <li>(6) Person who is permanently and totally disabled (State definition) and age 18 or older.</li> </ul>
<b>b. Age 21 to 64</b>	<ul style="list-style-type: none"> <li>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</li> <li>(2) Person who is blind (State definition).</li> <li>(3) Person who is permanently and totally disabled (State definition).</li> </ul>
<b>c. Age 65 or older</b>	<ul style="list-style-type: none"> <li>(1) Individual who has attained age 65.</li> </ul>
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <ul style="list-style-type: none"> <li>(1) Recipients of OAA, AB, APTD, and AFDC.</li> <li>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</li> <li>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</li> </ul> <p style="text-align: center;"><i>Optional</i></p> <ul style="list-style-type: none"> <li>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</li> <li>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</li> <li>(6) Children who would be eligible for AFDC except for the presence of a stepfather in the home.</li> </ul>

**C. Eligibility for Medical Assistance (Continued)**

	<i>Optional</i>
<b>b. FFP Claimed in Administrative Costs Only</b>	None.
<b>4. Coverage of the Medically Needy</b>	Not included.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	Not applicable.
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.
<b>7. Identification to Vendors of Persons Eligible</b>	A Medical Identification Card is issued by the fiscal agent (Mutual Medical Insurance, Inc.) to AFDC recipients every month, and to OAA, AB, and APTD recipients every 6 months. Cards are also issued on the same periodic basis to persons eligible for medical assistance but not for a money payment. Expiration date appears on each card (e.g. end of month, end of June, or end of December), as well as the Medicaid Identification number, the name and address of payee, and birthdate of each person eligible in the case.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Division of Medical Services is the medical assistance unit of the State Department of Public Welfare. The Director (M.A. - Hospital Administration) is responsible to the Administrator of the agency. His staff consists of one full-time Supervisor (Medical Social Work) and four part-time consultants (dentist, pharmacist, physician, and medical social worker).
<b>2. Supervision of Statewide Operations</b>	Supervision of medical aspects of Statewide operations is accomplished through an agreement with the State Board of Health, whose staff is involved in details of the program.  Supervision of eligibility determination and other aspects of the program is accomplished through the regular field staff of the Division of Public Assistance of the State Department of Public Welfare.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Assistance Advisory Committee. It is composed of 16 members appointed by the State Administrator of Public Welfare. There are two ex officio members (a representative of the State Health Commissioner and a representative of the State Mental Health Department). Authority for the Committee is statutory.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Public Welfare does not directly engage in the day-to-day processing and payment of vendor claims, but fulfills its responsibility for such operations through the medium of a fiscal agent.



**D. Administration and Management (Continued)**

<b>b. Fiscal Agents</b>	<p>State agency has entered into 2 fiscal agent contracts, as follows:</p> <p>(1) Mutual Hospital Insurance, Inc. (Blue Cross) processes and pays all claims for inpatient and outpatient hospital services, skilled nursing home services, and rehabilitation centers.</p> <p>(2) Mutual Medical Insurance, Inc. (Blue Shield) processes and pays all other claims for medical services provided under the program.</p>
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Indiana as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 52.85.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially to the State Department of Public Welfare. Amount appropriated is not differentiated as to individual programs of the Department nor as to fiscal year. Unobligated balance reverts to the General Fund at the end of the biennium.
<b>4. Deficit Financing</b>	Deficit financing is not prohibited. Appropriation Act specifies that if the sums appropriated are not sufficient to enable the Department to meet its obligations, "there is hereby appropriated such further sums as may be necessary for such purposes, the amount, however, to be subject to the approval of the State Budget Agency and the Governor."

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Social Services

January 1, 1970

IOWA

**A. General Information**

<b>1. Legal Base</b>	Section 234, Code of Iowa (1966)
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1967. Original plan approved by the Federal agency on September 27, 1967.
<b>3. Administrative Responsibility</b>	The Department of Social Services serves as the single State agency with responsibility for supervising the administration of the program on a Statewide basis through a system of local agencies (99 county Departments of Social Welfare).
<b>4. Historical Background</b>	<p>Provisions for vendor payments for the cost of medical care under the public assistance programs began in January 1959. The State statute authorized a comprehensive scope of care for OAA, AB, and AFDC (there was no APTD program) but the services originally provided were limited to physicians' services, prescribed drugs, and outpatient clinic services (diagnostic and therapeutic). (There was no provision under the public assistance programs for payment for inpatient hospital care or surgery.) In June 1959, the service of podiatrists was added to the scope of the program and in April 1960, dental services. In January 1961, vendor payments for nursing home care for OAA recipients began. The new APTD program had begun in January 1960, but it was not until July 1, 1965, that vendor payments for medical care were made under this program, covering the same kinds of services provided to AB and AFDC recipients. In March 1966, nursing home care for these three categories was added to the list of services for which vendor payments were made.</p> <p>Enabling legislation had been enacted in 1961 for a program of Medical Assistance for the Aged (a Federal-State program for persons age 65 and older who were not recipients of public assistance but met certain criteria of medical and financial need). No appropriation was made until 1963, when services began in December. The scope of services included inpatient hospital care and up to six months of post-hospital nursing home care as well as the kinds of services provided under the public assistance categories. Because of financial difficulties, in late 1965 limitations were placed on the duration of hospital and nursing home care and the number of physicians' visits and some services were eliminated entirely (dental services, services of private duty and of visiting nurses, and services of podiatrists, optometrists, opticians, and chiropractors). Some of these limitations were eased in 1966 and other adjustments made in both the MAA program and the medical services for OAA in order to coordinate with the title XVIII Medicare program which began in July 1966.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exception:</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	<p>Provided. Up to 10 days per admission (no circumvention permitted, such as transfer to another hospital). Ward or other multiple bed accommodation only; no additional payment for private room. Payment not made for services provided at University Hospitals to recipients approved as county quota patients. No requirements for prior authorization. Reimbursement on basis of reasonable cost (same as paid to the facility by Medicare). Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>
<b>b. In Institutions for Tuberculosis</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (same as paid to the facility by Medicare). Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).
<b>3. Other Laboratory and X-ray Services</b>	Provided. By independent laboratories certified to participate in Medicare program. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charges (same as paid to the facility by Medicare). Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No limitations, except that services in out-of-State nursing homes are not provided. Physician's certification and periodic recertification required. Fiscal agent's determination of need for skilled level of nursing care required, based on "Medical Information Form" submitted by facility at time of patient's admission and upon rendering of each subsequent claim for payment. Monthly authorization of payment, issued to facility by county department, required, showing amount for which no payment is to be made by fiscal agent (e.g., insurance or other resource, and amount of patient's available income in excess of \$10 a month which may be retained for personal needs). Reimbursement on basis of facility's usual, customary, and reasonable charges, not to exceed reasonable cost (Medicare principles and standards applied). Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. Payment for physician's services to hospital inpatient, even though period of authorized stay has elapsed. Payment for dispensed drugs made to physicians maintaining an office in a community where there is no licensed retail pharmacy. Reimbursement on basis of physician's usual, customary, and reasonable charges, not to exceed maximum allowable charges for procedures as determined by fiscal agent (same payment structure in effect for physicians' services in Part B of title XVIII in Iowa). Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. In home, office, or clinic. Limited to services set forth in Department's Podiatry Fee Schedule. Authorization by State office required for payment for visits in excess of 4 per month for acute conditions or one per month for chronic conditions. Reimbursement on basis of practitioner's usual, customary, and reasonable charges; payment not to exceed maximum allowances for procedures as shown in Podiatry Fee Schedule. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).
<b>b. Optometrists</b>	Provided. Limited to list (extensive) of professional services and materials covered by Optometrist's Fee Schedule. No requirements for prior authorization. Reimbursement for services on basis of practitioner's usual and customary charge; payment not to exceed maximum allowances shown in Optometrist's Fee Schedule. Reimbursement for dispensed materials on basis of laboratory costs as evidenced by invoice, except that \$7 is maximum payment allowable for frames. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).

**B. Medical and Remedial Care and Services (Continued)**

c. Chiropractors	Provided. In home, office, or clinic. Limited to 4 visits per month (not more than one visit per day); X-ray not more than once in a 12-month period. No extensions. No requirements for prior authorization. Reimbursement on basis of practitioner's usual and customary charge; payment not to exceed maximum allowances shown in Chiropractor's Fee Schedule. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).
d. Other	Not provided.
8. Home Health Care Services	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. As furnished by certified home health agency on physician's prescription in accordance with treatment plan. Limited to 100 visits per year (combined total of all visits from home health agency), plus 100 additional visits following discharge from a hospital or extended care facility after at least 3-day inpatient hospital stay. No requirements for prior authorization. Reimbursement on basis of reasonable cost (according to Medicare principles and standards). Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p> <p>(b) Services of home health aide. Provided. As furnished by certified home health agency on physician's prescription in accordance with treatment plan. Limited to 100 visits per year (combined total of all visits from home health agency), plus 100 additional visits following discharge from a hospital or extended care facility after at least 3-day inpatient hospital stay. No requirements for prior authorization. Reimbursement on basis of reasonable cost (according to Medicare principles and standards). Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p> <p>(c) Medical supplies, equipment, and appliances. Including rental or purchase of durable equipment. No limitations, except that medical and sickroom supplies must be ordered by physician for specific rather than an incidental use. Prior authorization by county department required for replacement (but not for repair) of equipment and for all items costing in excess of \$50; additional approval by State office required for items costing in excess of \$150; authorization includes statement of maximum amount approved for payment. Reimbursement for medical and sickroom supplies not to exceed manufacturer's suggested minimum retail price or usual community price for item, whichever is lower. Reimbursement for medical equipment and appliances on basis of maximum allowable amount established by State department. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>
9. Private Duty Nursing Services (RN or LPN)	Not provided.
10. Clinic Services (Other than Hospital)	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of schedule of maximum allowances for physicians' services. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).
11. Dental Services	Provided. No limitations. Prior authorization by fiscal agent's dental consultant required for orthodontia, periodontia, partial dentures, complete dentures replacing existing dentures, and other procedures, supplies, and materials not listed in Dental Fee Schedule. No payments to dental laboratories. Reimbursement on basis of practitioner's usual and customary charges, not to exceed maximum amount allowable as shown in Dental Fee Schedules. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).
12. Physical Therapy and Related Services	<p>a. Physical Therapy</p> <p>Provided. When furnished by physician, hospital, skilled nursing home, or home health agency. (Payment not made to private-practicing therapist.) No limitations. No requirements for prior authorization. Reimbursement on variable basis according to type of provider furnishing the service. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>b. Occupational Therapy</b>	<p>Provided. As furnished by certified home health agency on physician's prescription in accordance with treatment plan. Limited to 100 visits per year (combined total of all visits from home health agency), plus 100 additional visits which follow discharge from hospital or extended care facility after at least 3-day inpatient hospital stay. No requirements for prior authorization. Reimbursement on basis of reasonable cost (according to Medicare principles and standards). Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>								
<b>c. Speech Therapy</b>	<p>Provided. As furnished by certified home health agency on physician's prescription in accordance with treatment plan. Limited to 100 visits per year (combined total of all visits from home health agency), plus 100 additional visits which follow discharge from hospital or extended care facility after at least 3-day inpatient hospital stay. No requirements for prior authorization. Reimbursement on basis of reasonable cost (according to Medicare principles and standards). Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>								
<b>d. Audiology</b>	<p>Provided. When furnished by or under direct supervision of a physician. No limitations. No requirements for prior authorization. Reimbursement on basis of schedule of maximum allowances for physicians' services. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>								
<b>13. Prescribed Drugs</b>	<p>Provided. Legend drugs and insulin. Prescription limited to 30-day supply except for maintenance drugs which may be prescribed in package quantities up to 100-day supply. No refills; new prescription required on each occasion. No requirements for prior authorization. Reimbursement to retail pharmacist on basis of provider's usual and customary charges, but not to exceed cost of drug as shown in current Redbook or Bluebook plus professional fee of \$2; same basis for compounded prescription. Reimbursement to hospital pharmacy for drugs dispensed to outpatients on basis of provider's usual and customary charge, not to exceed payment to retail pharmacy for same items. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>								
<b>14. Prosthetic Devices</b>	<table> <tr> <td data-bbox="150 1180 293 1205"><b>a. Eyeglasses</b></td><td data-bbox="488 1180 1516 1379"> <p>Provided. Including artificial eyes; excluding sunglasses. Limit of one pair of frames for a recipient, except when original glasses are lost or damaged beyond repair. No requirements for prior authorization. Reimbursement to optometrist for dispensed materials on basis of laboratory costs as evidenced by invoice, with maximum payment of \$7 allowed for frames. Reimbursement to optician on basis of maximum allowances shown on Optician's Fee Schedule. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p> </td></tr> <tr> <td data-bbox="150 1417 320 1442"><b>b. Hearing Aids</b></td><td data-bbox="488 1417 1516 1558"> <p>Not provided.</p> <p>[For money-payment recipients of OAA, AB, APTD, and AFDC, an initial allowance for the purchase of a hearing aid, and a monthly allowance for maintenance, may be included in the grant when need for the item has been established.]</p> </td></tr> <tr> <td data-bbox="150 1596 280 1621"><b>c. Dentures</b></td><td data-bbox="488 1596 1516 1736"> <p>Provided. No limitations. Prior authorization by fiscal agent's dental consultant required for partial dentures and for complete dentures replacing existing dentures. No payments to dental laboratories. Reimbursement on basis of practitioner's usual and customary charges, not to exceed maximum amount allowable as shown in Dental Fee Schedules. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p> </td></tr> <tr> <td data-bbox="150 1774 360 1827"><b>d. Other Prosthetic Devices</b></td><td data-bbox="488 1774 1516 2024"> <p>Provided. Braces and prosthetic devices, including artificial limbs and other devices and appliances designed to replace missing or malfunctioning body members. Physician's prescription required. Orthopedic shoes not provided. No requirements for prior authorization. Reimbursement on basis of maximum allowable amount established by State Department of Social Services. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p> <p>[For money-payment recipients of OAA, AB, APTD, and AFDC, an allowance for purchase of orthopedic shoes may be included in the grant when need for the item has been established].</p> </td></tr> </table>	<b>a. Eyeglasses</b>	<p>Provided. Including artificial eyes; excluding sunglasses. Limit of one pair of frames for a recipient, except when original glasses are lost or damaged beyond repair. No requirements for prior authorization. Reimbursement to optometrist for dispensed materials on basis of laboratory costs as evidenced by invoice, with maximum payment of \$7 allowed for frames. Reimbursement to optician on basis of maximum allowances shown on Optician's Fee Schedule. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>	<b>b. Hearing Aids</b>	<p>Not provided.</p> <p>[For money-payment recipients of OAA, AB, APTD, and AFDC, an initial allowance for the purchase of a hearing aid, and a monthly allowance for maintenance, may be included in the grant when need for the item has been established.]</p>	<b>c. Dentures</b>	<p>Provided. No limitations. Prior authorization by fiscal agent's dental consultant required for partial dentures and for complete dentures replacing existing dentures. No payments to dental laboratories. Reimbursement on basis of practitioner's usual and customary charges, not to exceed maximum amount allowable as shown in Dental Fee Schedules. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>	<b>d. Other Prosthetic Devices</b>	<p>Provided. Braces and prosthetic devices, including artificial limbs and other devices and appliances designed to replace missing or malfunctioning body members. Physician's prescription required. Orthopedic shoes not provided. No requirements for prior authorization. Reimbursement on basis of maximum allowable amount established by State Department of Social Services. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p> <p>[For money-payment recipients of OAA, AB, APTD, and AFDC, an allowance for purchase of orthopedic shoes may be included in the grant when need for the item has been established].</p>
<b>a. Eyeglasses</b>	<p>Provided. Including artificial eyes; excluding sunglasses. Limit of one pair of frames for a recipient, except when original glasses are lost or damaged beyond repair. No requirements for prior authorization. Reimbursement to optometrist for dispensed materials on basis of laboratory costs as evidenced by invoice, with maximum payment of \$7 allowed for frames. Reimbursement to optician on basis of maximum allowances shown on Optician's Fee Schedule. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>								
<b>b. Hearing Aids</b>	<p>Not provided.</p> <p>[For money-payment recipients of OAA, AB, APTD, and AFDC, an initial allowance for the purchase of a hearing aid, and a monthly allowance for maintenance, may be included in the grant when need for the item has been established.]</p>								
<b>c. Dentures</b>	<p>Provided. No limitations. Prior authorization by fiscal agent's dental consultant required for partial dentures and for complete dentures replacing existing dentures. No payments to dental laboratories. Reimbursement on basis of practitioner's usual and customary charges, not to exceed maximum amount allowable as shown in Dental Fee Schedules. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p>								
<b>d. Other Prosthetic Devices</b>	<p>Provided. Braces and prosthetic devices, including artificial limbs and other devices and appliances designed to replace missing or malfunctioning body members. Physician's prescription required. Orthopedic shoes not provided. No requirements for prior authorization. Reimbursement on basis of maximum allowable amount established by State Department of Social Services. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).</p> <p>[For money-payment recipients of OAA, AB, APTD, and AFDC, an allowance for purchase of orthopedic shoes may be included in the grant when need for the item has been established].</p>								

**B. Medical and Remedial Care and Services (Continued)**

<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices. No limitations. No requirements for prior authorization. Reimbursement on variable basis according to type of provider furnishing the service. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Subject to conditions governing emergency services provided by non-participating hospital under Title XVIII. Provisions in effect for inpatient and outpatient hospital services are applicable (See Items D.1 and 2).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. When medically necessary and when patient's condition precludes use of other means of transportation. Must be furnished by provider of ambulance service eligible to participate in Medicare program. No payment for ambulance service to receive outpatient care except in an emergency. No requirements for prior authorization. Reimbursement on basis of provider's usual, customary, and reasonable charge; payment not to exceed amount provider ordinarily charges to general public. Claims processed and paid by fiscal agent (Hospital Service, Inc., of Iowa and Iowa Medical Service).
<b>b. Other</b>	Not provided.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	<ul style="list-style-type: none"> <li>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</li> <li>(2) Child in AFDC foster care.</li> <li>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</li> <li>(4) Person who is blind (State definition) and age 18 or older.</li> <li>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</li> <li>(6) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</li> </ul>



## C. Eligibility for Medical Assistance (Continued)

<p>b. Age 21 to 64</p> <p>c. Age 65 or older</p>	<p>(7) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(8) Person who is blind (State definition).</p> <p>(9) Person who is permanently and totally disabled (State definition).</p> <p>(10) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p>(1) Individual who has attained age 65.</p>
<p>3. Coverage of the Categorically Needy</p> <p>a. FFP Claimed in Medical and Administrative Costs</p> <p>b. FFP Claimed in Administrative Costs Only</p>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a. (3), above, are living.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only)</p> <p style="text-align: center;"><i>Optional</i></p> <p>(8) Dependent relatives, other than the essential spouse, whose needs are included in the assistance grant but are not eligible for financial participation. These relatives are eligible for medical care within the scope of the plan.</p>
<p>4. Coverage of the Medically Needy</p>	<p>Not included.</p>
<p>5. Financial Criteria</p> <p>a. For Categorically Needy Persons</p> <p>b. For Medically Needy Persons</p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>Not applicable.</p>
<p>6. Financial Responsibility of Relatives</p>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>7. Identification to Vendors of Persons Eligible</b>	<p>A white Medical Assistance Identification Card is issued by the State office to each case certified as eligible which shows case name, case number, and names of all eligible dependent members of the family. In addition, the Identification Card gives information as to availability of outside medical resources by an entry reading "None", or "Health Insurance" (alerting hospitals and physicians to request authorization from county department), or "Excess Income and/or Health Insurance" (alerting all vendors except skilled nursing homes to request authorization from county office). This Identification Card is to be retained and used by recipient so long as eligibility continues. In addition, each case receives a colored Monthly Eligibility Card verifying eligibility for the month shown on the card. This Eligibility Card, which varies in color from month to month, is mailed to money payment recipients in the envelop containing the assistance check, and is issued to "medical assistance only" cases by the local department. (After computer programming changes are made, cards to "medical only" cases will also be issued by State office). A plastic pouch is supplied to recipients in which cards are to be kept.</p>
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**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Director of the Bureau of Medical Services (the medical assistance unit), a physician, is directly responsible to the Deputy Commissioner of the Department of Social Services. The Bureau has an additional full-time professional staff of five: an Assistant Director (social worker), Chief of the Division of Program Standards and Development (social worker), Chief of the Division of Utilization Review (pharmacists), and two Medical Program Supervisors.</p>								
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of Statewide operations is accomplished through the regular field staff of the agency (10 area social service administrators and supporting staff) who are assigned to specific areas of the State.</p>								
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Medical Assistance Advisory Council. It is composed of 18 members. There are no ex officio members, but the list of members given in the statute includes the Commissioner of Health and the Dean of the University of Iowa School of Medicine. Authority for the Council is statutory.</p>								
<b>4. Buy-In Agreement</b>	<p>State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.</p>								
<b>5. Claims Payment Process</b>	<table border="1"> <tr> <td data-bbox="65 1287 434 1392"> <b>a. State and Local Agencies</b> </td><td data-bbox="434 1287 1505 1392"> <p>The Department of Social Services does not directly engage in the day-to-day processing and payment of vendor claims, but fulfills its responsibility for these operations through the medium of a fiscal agent.</p> </td></tr> <tr> <td data-bbox="65 1392 434 1518"> <b>b. Fiscal Agents</b> </td><td data-bbox="434 1392 1505 1518"> <p>State agency has entered into a fiscal agent contract with Hospital Services, Inc., of Iowa (Blue Cross) and Iowa Medical Service (Blue Shield) for the processing and payment of all claims for medical services provided under the program.</p> </td></tr> <tr> <td data-bbox="65 1518 434 1602"> <b>c. Prepaid Capitation Arrangements</b> </td><td data-bbox="434 1518 1505 1602"> <p>None.</p> </td></tr> <tr> <td data-bbox="65 1602 434 1728"> <b>d. Payments to Non-Medical Institutions</b> </td><td data-bbox="434 1602 1505 1728"> <p>None.</p> </td></tr> </table>	<b>a. State and Local Agencies</b>	<p>The Department of Social Services does not directly engage in the day-to-day processing and payment of vendor claims, but fulfills its responsibility for these operations through the medium of a fiscal agent.</p>	<b>b. Fiscal Agents</b>	<p>State agency has entered into a fiscal agent contract with Hospital Services, Inc., of Iowa (Blue Cross) and Iowa Medical Service (Blue Shield) for the processing and payment of all claims for medical services provided under the program.</p>	<b>c. Prepaid Capitation Arrangements</b>	<p>None.</p>	<b>d. Payments to Non-Medical Institutions</b>	<p>None.</p>
<b>a. State and Local Agencies</b>	<p>The Department of Social Services does not directly engage in the day-to-day processing and payment of vendor claims, but fulfills its responsibility for these operations through the medium of a fiscal agent.</p>								
<b>b. Fiscal Agents</b>	<p>State agency has entered into a fiscal agent contract with Hospital Services, Inc., of Iowa (Blue Cross) and Iowa Medical Service (Blue Shield) for the processing and payment of all claims for medical services provided under the program.</p>								
<b>c. Prepaid Capitation Arrangements</b>	<p>None.</p>								
<b>d. Payments to Non-Medical Institutions</b>	<p>None.</p>								

**E. Financing**

<b>1. Federal Financial Participation</b>	<p>The Federal Medical Assistance percentage for Iowa as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 55.27.</p>
<b>2. State/Local Participation</b>	<p>State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.</p>



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**E. Financing (Continued)**


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<b>3. Source of State Funds</b>	<p>State's share of program costs is derived from appropriations made biennially to the State Department of Social Services, with a line item for "medical assistance" appropriating a specific amount for each year of the biennium. Unexpended balance at the end of the first fiscal year may be carried over to the second year but reverts to the General Fund at the end of the biennium.</p>
<b>4. Deficit Financing</b>	<p>There is no authority for deficit financing. If additional funds are needed before the next appropriation period, the appropriation act authorizes transfer of funds from the old age assistance fund to the medical assistance fund, upon request of the Department and with approval of the State Executive Council. If this avenue of relief should prove inadequate, a supplemental appropriation would have to be obtained from the State legislature or the program be curtailed.</p>

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## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Social Welfare

January 1, 1970

KANSAS

**A. General Information**

<b>1. Legal Base</b>	K.S.A. 1965 Supp. 39-708, 39-709 and 39-713, as amended by House Bill 1608 of the 1967 Kansas legislature.
<b>2. Beginning Dates</b>	Program went into operation on June 1, 1967. Original plan approved by the Federal agency on October 10, 1967.
<b>3. Administrative Responsibility</b>	The Department of Social Welfare is the single State agency with responsibility for supervising the administration of the program by 105 county departments of social welfare.
<b>4. Historical Background</b>	The first Statewide program for vendor payment of medical care costs with Federal financial participation began in 1954 and was completely revised to meet Federal requirements in 1957. It consisted of county plans, subject to State review, with local tax funds supplemented by State funds on a matching basis to meet the non-Federal share of the costs. All public assistance categories were covered. In 1963, a uniform medical program for all persons receiving public assistance was authorized by the legislature, together with Medical Assistance for the Aged (a Federal-State program for persons age 65 and over who were not recipients of public assistance but met certain criteria of financial and medical need). These programs were implemented by the State Board of Social Welfare in January 1964. Nursing home care was provided only through the money payment to recipients of public assistance and was included in MAA vendor payment program.
<b>5. Scope of Coverage</b>	Program provides for coverage of both categorically and medically needy persons. (See Items C. 3. and C. 4., below.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (See Items B. 1. b. and c.; B. 4. b. and c.)</p> <p>Early and periodic screening and diagnosis (See Item B. 5.) is provided only for individuals under age 21.</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. Limited only by judgment and decision of Hospital Utilization Review Committee. On December 1, 1969, final judgment on Utilization was vested in the Physicians' Review Panel of the fiscal agent. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Service Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older. In public and private institutions. No requirements for prior authorization. Reimbursement on basis of an average daily rate based on reasonable cost, including cost of physicians' services. Claims processed by State Department of Social Welfare; paid by State Department of Administration.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older. In public and private institutions. No requirements for prior authorization. Reimbursement on basis of an average daily rate based on reasonable cost, including cost of physicians' services. Claims processed by State Department of Social Welfare; paid by State Department of Administration.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Service Assn. and Kansas Physicians' Service); paid by State Department of Administration.



**B. Medical and Remedial Care and Services (Continued)**

<b>3. Other Laboratory and X-ray Services</b>	Provided. In independent laboratories certified by Medicare. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary fees as filed with fiscal agent. Claims processed and amount of correct payment determined by fiscal agent. (Kansas Hospital Service Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No limitations. Prior authorization required for persons under age 21. Reimbursement on basis of rates established by negotiation between county board of social welfare and the nursing home administrator. (Exception: In counties classified as maximum levy, rates are subject to approval by the State Board of Social Welfare upon recommendation of county board.) Claims processed and paid by county welfare office; except that claims from extended care facilities involving coinsurance for Medicare beneficiaries are processed and the correct amount of payment determined by fiscal agent (Kansas Hospital Service Assn. and Kansas Physicians' Service) and the coinsurance paid by the State Department of Administration.
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older. In public and private institutions. No requirements for prior authorization. Reimbursement on basis of an average daily rate based on reasonable cost, including cost of physicians' services. Claims processed by State Department of Social Welfare; paid by State Department of Administration.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older. In public and private institutions. No requirements for prior authorization. Reimbursement on basis of an average daily rate based on reasonable cost, including cost of physicians' services. Claims processed by State Department of Social Welfare; paid by State Department of Administration.
<b>5. Early and Periodic Screening,, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in regulations of The Secretary of the U.S. Department of Health, Education, and Welfare.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. Payment made for services of one physician only for same diagnosis, except for consultation and specialty. No requirements for prior authorization. Reimbursement on basis of usual and customary fees, within range maximum determined by all fees filed. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Service, Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Limited to services requiring professional skill and judgment. Routine foot care excluded. Palliative care payable only in cases of infections associated with such illnesses as diabetes or circulatory disturbance. No requirements for prior authorization. Reimbursement on basis of reasonable, usual, and customary fees within range maximum of fees paid for each procedure. Materials reimbursable at acquisition cost. Claims processed and correct amount of payment determined by fiscal agent (Kansas Hospital Service Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>b. Optometrists</b>	Provided. No limitations. Prior authorization required for refraction corrections less than a certain minima; second refraction within 12 months; contact lenses; multiple prescriptions; and visual training therapy. Reimbursement for professional services on basis of range maximum developed from fee registrations; for materials on basis of acquisition cost. Claims processed and correct amount of payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>c. Chiropractors</b>	Provided. Limited to cases where a physician is not rendering care to patient for the same diagnosis. Prior authorization required for therapy over period in excess of 90 days. Multiple visits per day or unusual number of visits subject to review by Utilization Committee. Laboratory tests limited to urinalysis. No payment for drugs provided by practitioner. Reimbursement for professional services on basis of usual, customary, and reasonable fees within the range maximum of all fees filed; for materials on basis of acquisition cost. Claims processed and correct amount of payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.

**B. Medical and Remedial Care and Services (Continued)**

<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided only if furnished by home health agency certified for Medicare. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and correct amount of payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.</p> <p>(b) Services of home health aids. Provided only if furnished by home health agency certified for Medicare. No limitation. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations, except that durable equipment is made available only on a rental basis. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims from hospitals and home health agencies processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Physicians' Service); paid by State Department of Administration. Claims from other providers processed and paid by county welfare office.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Provided. Limited to patients in hospitals which do not have intensive care service. No requirements for prior authorization, but must be furnished on direction of physician. Reimbursement on basis of usual and customary charges. Claims processed and paid by county welfare office.
<b>10. Clinic Services (Other than Hospital)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary fees. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>11. Dental Services</b>	Provided. No limitations. Prior authorization required for orthodontia, dentures and partial dentures under certain circumstances, and treatment estimated to cost \$600 or more. Reimbursement on basis of usual, customary, and reasonable fees within range maximum of all fees filed. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. No limitations, but must be under direction of physician. No requirements for prior authorization. Reimbursement on basis of usual and customary fees within range maximum of all fees filed. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>b. Occupational Therapy</b>	Not provided.
<b>c. Speech Therapy</b>	Not provided.
<b>d. Audiology</b>	Provided. No limitations, but must be upon referral of physician. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by county welfare office.



**B. Medical and Remedial Care and Services (Continued)**

<b>13. Prescribed Drugs</b>	Provided. Legend drugs and certain non-legend drugs used for treatment of specified physical conditions. No limitations. Prior authorization required only when maximum charge for prescription exceeds \$25. Reimbursement on basis of acquisition cost plus mark-up of 50%; additional \$1 for compound prescription; additional 50¢ for prescription costing less than \$5. Cost plus-mark-up not to exceed regular charges for non-welfare customers. Regardless of mark-up formula, provider (pharmacy or physician with dispensing permit from Department of Social Welfare) may charge minimum price of \$1.25 for a prescription. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Provided. No limitations. Prior authorization required for contact lenses and for multiple prescriptions. Payments made to physicians, optometrists, and optical dispensers. Reimbursement for professional services on basis of usual, customary, and reasonable fees as registered with the fiscal agent, provided they are within range maximum of fees filed for each procedure; for materials at acquisition cost. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.
b. Hearing Aids	Provided. After examination and determination of need by a physician. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary fees. Claims processed and paid by county welfare office.
c. Dentures	Provided. No limitations. Prior authorization required for full and partial dentures under certain circumstances. Reimbursement on basis of usual and customary fees. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.
d. Other Prosthetic Devices	Provided as follows: (1) Prosthetic devices installed within the body or to replace such devices. No limitations or requirements for prior authorization except must be under direction of a physician. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration. (2) Artificial limbs, braces, and orthopedic shoes, including replacements. No limitations or requirements for prior authorization, but must be under direction of a physician. Claims processed and paid by county welfare office.
<b>15. Family Planning Services</b>	Provided. Consisting of physicians' services, drugs, supplies, and devices. No limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable fees for physicians' services; acquisition cost plus 50% for materials. Vendor payments made to physicians and pharmacies. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Reimbursement on basis of usual, customary, and reasonable charges. Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.

**B. Medical and Remedial Care and Services (Continued)**

<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges, Claims processed and amount of correct payment determined by fiscal agent (Kansas Hospital Assn. and Kansas Physicians' Service); paid by State Department of Administration.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. When medically necessary. No limitations. No requirements for prior authorization. Reimbursement on basis of rates negotiated between county welfare office and provider; except for Medicare deductibles, which are paid at current title XVIII rate. Claims processed and paid by county welfare offices.
<b>b. Other</b>	Provided. Transportation by other appropriate means and related travel expenses, with prior authorization from and by special arrangements with county welfare office. Reimbursement on basis of negotiation between county agency and the provider. Claims processed and paid by county welfare office.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility, an individual is retroactively entitled to assistance as early as the first day of the month preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C. 3. a.:
<b>a. Under Age 21</b>	(1) Individual under age 21
<b>b. Age 21 to 64</b>	(1) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father. (2) Person who is blind (State definition). (3) Person who is permanently and totally disabled (State definition). (4) Essential spouse (title XIX definition) of a recipient of AABD.
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of AABD and AFDC.</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p>



**C. Eligibility for Medical Assistance (Continued)**

	<i>Optional</i>
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p>(4) Persons eligible for but not receiving AABD or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC program but who would be eligible for such assistance if they left the facility.</p> <p>(6) Parents or caretaker relatives (as specified in the State's AFDC plan) with whom dependent children described in Item C. 3. a. (3), above, are living.</p> <p>(7) All individuals under 21.</p> <p>(8) Essential spouse [title XIX definition] of a recipient of AABD. (Categorically needy only.)</p>
<b>b. FFB Claimed in Administrative Costs Only</b>	<p>(1) Individuals meeting the State's eligibility requirements for general assistance. (Limited to the categorically needy.)</p> <p>(2) Essential relatives other than those described in Item C. 3. a. (8), above, who are not eligible in their own right for assistance under a Federal category.</p>
<b>4. Coverage of the Medically Needy</b>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C. 3. a. (1) through (7), and Item C. 3. b. (2), above, whose income and resources exceed the levels established under the State's plan for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C. 5. b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.</p>
<b>5. Financial Criteria</b>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p>
<b>a. For Categorically Needy Persons</b>	<p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>
<b>b. For Medically Needy Persons</b>	<p>(1) <i>Income</i>  Net annual income (defined as "net take-home pay" after required deduction of withholding taxes and OASDI) which may be retained for basic maintenance needs: \$1600 for one person, \$2200 for 2 persons, \$2600 for 3 persons, \$3000 for 4 persons, plus \$400 for each additional member of the family.</p> <p>For person in long-term care in a medical facility, \$250 annually may be retained, plus an additional \$250 for spouse who is also in long-term care in a medical facility, or an additional \$1600 per year for spouse who is living at home.</p> <p>(2) <i>Resources</i>  Equity in home may be retained up to \$12,500, or up to 150% of moderate home value allowed in each county for a public assistance recipient, if less. ("Home" is defined as a house in which the individual lives or from which he is temporarily absent, plus contiguous land not in excess of 40 acres.)</p> <p>Household furnishings and personal effects may be retained without regard to value or quantity.</p> <p>Equity in other personal and real property (including excess equity in the home) is permitted up to \$1600 for one person, \$2200 for 2 persons, \$2600 for 3 persons, \$3000 for 4 persons, and \$100 for each additional person in the home.</p> <p>Excess resources do not render an individual ineligible, but agency's obligation for payment of medical expenses does not begin until individual has incurred medical expenses equal to such excess.</p>

**C. Eligibility for Medical Assistance (Continued)**

6. Financial Responsibility of Relatives	The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children under age 21 and for blind or permanently and totally disabled children whose incapacity occurred prior to attainment of age 21.
7. Identification to Vendors of Persons Eligible	A Medical Identification Card is issued to new cases upon certification of eligibility by the county welfare office, which is valid until February of the following year. In February of each year, new cards are issued to all on-going cases covering the next 12-month period.

**D. Administration and Management**

1. Medical Assistance Unit	The Division of Medical Services (medical assistance unit) of the Department of Social Welfare is headed by a Director of Medical Services who is directly responsible to the Director of the Department of Social Welfare. Qualification of incumbent Director is based upon 3 years experience in serving in the same capacity under the State's previous medical program. In addition to the Director, the full-time staff consists of a psychiatric social worker (MSW), a Nursing Home Coordinator, and an Administrative Assistant. The professional staff of the Division also includes the part-time services of a Medical Services Coordinator (M.D.), a Psychiatrist (M.D.), a Pharmaceutical Consultant, a Dental Consultant, and a Consultant in Psychiatry. Also available on a part-time basis are the services of an auditor consultant (C.P.A.) who is employed in another organizational segment of the Department.
2. Supervision of Statewide Operations	Supervision of Statewide operations is accomplished through the activities of the staff of the Division of Field Services, which includes 15 persons (M.S.W.) engaged in supervisory activities.
3. Advisory Council	The State advisory body for title XIX is known as the Governor's Advisory Committee to the State Board of Social Welfare on the Medical Assistance Program. The Committee consists of 22 members, appointed by the Governor, and has in addition 3 ex officio members (Director of the State Department of Social Welfare, Director of State Department of Health, and Director of Division of Maternal and Child Health). Selection of the chairman is made by vote of the membership. Authority for the Committee is administrative.
4. Buy-In Agreement	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all persons age 65 or older who are eligible for benefits under both title XVIII of the Social Security Act and the State's program under title XIX.
5. Claims Payment Process	a. State and Local Agencies The State Department of Administration makes direct payments to vendors for all medical care and services provided under the program with the exception of private duty nursing services, audiology, hearing aids, and certain prosthetic devices, which are processed and paid by the local county departments of social welfare.
	b. Fiscal Agents Kansas Blue Cross-Blue Shield (Kansas Hospital Service Association, Inc., and Kansas Physicians' Service, Inc.) serves as fiscal agent for the Department. The fiscal agent receives, processes, audits, and approves provider claims for subsequent payment by the State Department of Administration; prepares and distributes manuals to providers; and works with State agencies in analyzing utilization of services.
	c. Prepaid Capitation Arrangements None.
	d. Payments to Non-Medical Institutions None.



**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance Percentage for Kansas as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 57.78.
<b>2. State/Local Participation</b>	State and local funds are used in financing the non-Federal share of costs of both medical assistance and administration in the following proportions: 52% State funds, 48% local funds.
<b>3. Source of State Funds</b>	State's share of program costs are derived from appropriations from State General Funds. Appropriations are made annually; unobligated balance may not be carried over to next fiscal year.
<b>4. Deficit Financing</b>	When additional funds are needed to meet a deficit before the next appropriation period, they are obtained either by a legislative deficiency appropriation or by appeal to the Budget Division of the State Finance Council. Securing of additional funds other than through appropriation is dependent upon availability of moneys in pooled fund.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Economic Security

January 1, 1970

KENTUCKY

**A. General Information**

<b>1. Legal Base</b>	Chapter 205, Kentucky Revised Statutes, as amended. (Special authorizing legislation for the program was not deemed necessary. Adaptation of pre-existing authority was accomplished through enactment of Chapter 134, Laws 1966, Kentucky Regular Session, which provided that KRS 205.510 to 205.610, 205.991, and 211.106 "shall be known as the 'Medical Assistance Act.'")
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on September 23, 1966.
<b>3. Administrative Responsibility</b>	The Department of Economic Security is the single State agency with responsibility for administering the program on a Statewide basis through 71 field offices and 121 local county public assistance offices. As required by State law, medical aspects of the program are handled by the Department of Health under contract with the Department of Economic Security.
<b>4. Historical Background</b>	Provision of medical care to public assistance recipients in all categories began in Kentucky in January, 1961. Concurrently, a Federal-State program of Medical Assistance for the Aged (MAA) was instituted providing medical care for persons age 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need. Prior to July 1966, hospital and nursing home services, physicians' and dentists' services, and prescribed drugs were provided for recipients in all categories, including MAA, subject to a variety of limitations. Due to limitations of funds, statutory authority which would have permitted comprehensive medical services was never fully implemented. Arrangements whereby the medical care aspects of the program were handled by the Department of Health under contract with the Department of Economic Security, as required by State Law, were initiated in 1961 and continued in the new Medical Assistance program under title XIX.
<b>5. Scope of Coverage</b>	Program provides for coverage of both the categorically needy and the medically needy.
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Certain services are provided only to persons over the age of 65 or under the age of 21. (See Items B. 1. b. and c., and B. 5).</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. Up to a maximum of 21 days per admission. No requirement for prior authorization, but stay beyond the 7th day must be reviewed by hospital's utilization review mechanism and approved prior to the 8th day. Reimbursement on basis of reasonable cost. Claims processed by Department of Health; paid by Department of Economic Security.
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older who are patients in public or private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (established on principles used for title XVIII). Claims processed by Department of Health; paid by Department of Economic Security.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older who are patients in public or private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (established on principles used for title XVIII). Claims processed by Department of Health; paid by Department of Economic Security.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed by Department of Health; paid by Department of Economic Security.



**B. Medical and Remedial Care and Services (Continued)**

3. Other Laboratory and X-ray Services	Provided. Specified limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed by Department of Health; paid by Department of Economic Security.
4. Skilled Nursing Home Services  a. General          b. In Institutions for Tuberculosis    c. In Institutions for Mental Diseases	Provided. For persons of all ages. Prior authorization requires documentation by physician and nursing home that person meets "patient status" requirements. Program reviews by professionals before written authorization to nursing home. No other limitations. Reimbursement on basis of full reasonable cost; interim rate established by title XVIII paid with end-of-year post audit adjustments; for full cost for first 180 days of patient's stay in any calendar year; \$7.50 per day for remainder of year, with supplementation, up to maximum reimbursement rate, from income of recipient or from payment by third party. Claims processed by Department of Health; paid by Department of Economic Security.  Not provided.  Not provided.
5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
6. Physicians' Services (M.D. and D.O.)	Provided. Doctor-patient contacts limited to a maximum of 2 per patient, per physician, per year of "Initial and Prolonged Followup Visits." No requirements for prior authorization. Reimbursement on basis of a usual, customary, and prevailing fee system; except for in-hospital services which are limited to an attendance fee, consultation fee, and radiologist/pathologist fee. Claims processed by Department of Health; paid by Department of Economic Security.
7. Services of Licensed Practitioners  a. Podiatrists  b. Optometrists  c. Chiropractors  d. Other	Not provided.  Not provided.  Not provided.  Not provided.
8. Home Health Care Services	The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home if authorized by patient's physician and documented in licensed home health agency:  (a) Intermittent or part-time nursing services. Provided if furnished by a home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of rates established under title XVIII standards. Claims processed by Department of Health; paid by Department of Economic Security.  (b) Services of home health aide. Provided if furnished by a home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of rate paid by Social Security Administration for title XVIII service. Claims processed by Department of Health; paid by Department of Social Security.  (c) Medical supplies, equipment, and appliances. Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided. [For public assistance recipients, a nursing care allowance of \$40 per month may be included in the money payment for AABD clients and for specified relatives in AFDC. <sup>1</sup>
<b>10. Clinic Services (Other than Hospital)</b>	Not provided.
<b>11. Dental Services</b>	Provided. General services, operative dentistry, endodontia, and extractions. Limited to items on fee schedule; prosthetic dentistry limited to denture repairs for adults and transitional appliances and space maintainers for children; orthodontia not provided. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed by Department of Health; paid by Department of Economic Security.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided only as part of hospital outpatient services and home health agency services. No payments to private-practicing therapists. No other limitations. No requirements for prior authorization. Reimbursement to hospitals on basis of reasonable cost; to home health agency on basis of rate paid by Social Security Administration for title XVIII service. Claims processed by Department of Health; paid by Department of Economic Security.
<b>b. Occupational Therapy</b>	Provided only as part of hospital outpatient services and home health agency services. No payments to private-practicing therapists. No other limitations. No requirements for prior authorization. Reimbursement to hospitals on basis of reasonable cost; to home health agency on basis of rate paid by Social Security Administration for title XVIII service. Claims processed by Department of Health; paid by Department of Economic Security.
<b>c. Speech Therapy</b>	Provided only as part of hospital outpatient services and home health agency services. No payments to private-practicing therapists. No other limitations. No requirements for prior authorization. Reimbursement to hospitals on basis of reasonable cost; to home health agency on basis of rate paid by Social Security Administration for title XVIII service. Claims processed by Department of Health; paid by Department of Economic Security.
<b>d. Audiology</b>	Not provided.
<b>13. Prescribed Drugs</b>	Provided. Legend drugs, limited to items on Medical Assistance Generic Drug List, and with restrictions on unit amount of prescription. Non-legend drugs provided only for nursing home patients. No requirements for prior authorization. Reimbursement on basis of pre-established wholesale cost plus professional fee of \$1.40 per prescription. Claims processed and paid by Department of Economic Security.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Not provided.
<b>b. Hearing Aids</b>	Not provided.
<b>c. Dentures</b>	Not provided.
<b>d. Other Prosthetic Devices</b>	Not provided.
<b>15. Family Planning Services</b>	Provided. Limited to physicians' services and prescription drugs. Supplies and devices not provided. No requirements for prior authorization. Reimbursement to physicians on basis of usual customary, and prevailing fee system; to pharmacists on basis of cost plus professional fee. Claims processed by Department of Health; paid by Department of Economic Security.
<b>16. Services of Christian Science Nurses</b>	Not provided.



### B. Medical and Remedial Care and Services (Continued)

17. Care and Services in Christian Science Sanatoria	Not provided.
18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)	Not provided.
19. Personal Care Services In Patient's Home	Not provided.
20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services	Provided. Limited to services of Community Mental Health Centers. Unlimited number of visits. No requirements for prior authorization. Reimbursement on basis of pre-established per visit rate based on certified costs audits.
21. Transportation	
a. Ambulance	Not provided.  [For public assistance recipients, the reasonable cost of transportation is included in the assistance plan as a special requirement.]
b. Other	Not provided.

### C. Eligibility for Medical Assistance

1. Date of Entitlement	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month of application.
2. Conditions of Eligibility (By Age Groups)	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C. 3. a.:
a. Under Age 21	<ul style="list-style-type: none"> <li>(1) Child deprived of parental support or care, living with a parent or caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father (title XIX only).</li> <li>(2) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</li> <li>(3) Child in AFDC foster care home.</li> <li>(4) Child placed in foster family home under supervision of an authorized public child welfare or child care agency. (Includes non-AFDC children.)</li> <li>(5) Person who is blind (State definition).</li> <li>(6) Person who is permanently and totally disabled (State definition), if age 18 or older.</li> </ul>
b. Age 21 to 64	<ul style="list-style-type: none"> <li>(1) Parent or caretaker relative and second parent (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</li> <li>(2) Person who is blind (State definition).</li> <li>(3) Person who is permanently and totally disabled (State definition).</li> </ul>
c. Age 65 or older	(1) Individual who has attained age 65.
3. Coverage of the Categorically Needy	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:

## C. Eligibility for Medical Assistance (Continued)

	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of AABD and AFDC.</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving AABD or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC program but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C. 3. a. (3), above, are living.</p> <p>(7) Children under age 21 placed in a foster family home under supervision of an authorized public child welfare or child care agency.</p> <p>(8) Children under 21 (and their parents) deprived of parental support due to unemployment of the parent. [Covered by the State's Medical Assistance Program but not by its AFDC program. Special definition of "unemployment" established for title XIX program purposes.]</p> <p>(9) Unborn child (and its parents) deprived of parental support due to death, absence, or incapacity of a parent, or unemployment of the father. [Covered by the State's Medical Assistance Program but not by its AFDC program.]</p> <p>(10) Children under age 21 who would be eligible for AFDC except for failure of parent to take paternity or support action.</p>
<p>b. FFP Claimed in Administrative Costs Only</p>	<p>None.</p>
<p>4. Coverage of the Medically Needy</p>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C. 3. a., above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C. 5. b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.</p>
<p>5. Financial Criteria</p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p>
<p>a. For Categorically Needy Persons</p>	<p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>
<p>b. For Medically Needy Persons</p>	<p>(1) <i>Income</i> Net annual income (defined as gross income less expenses directly related to earning of income) which may be retained for maintenance needs: \$1620 for one person, \$2220 for 2 persons, \$2820 for 3 persons, \$3420 for 4 persons, \$4020 for 5 persons, \$4500 for 6 persons, \$4980 for 7 persons, plus \$360 for each additional person.</p>



**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p>Person in long-term care in a medical facility may retain \$14 per month (or \$19 if making premium payments for Medicare or other health insurance) for personal needs, plus \$135 per month for maintenance needs of spouse living at home.</p> <p>(2) <i>Resources</i></p> <p>Homestead (defined as land and buildings thereon owned and either occupied as a home by recipient and his family or abandoned from use as a home because of illness, infirmity, isolated location, or uninhabitable condition) may be retained regardless of value or equity.</p> <p>Equity in income-producing real property (non-homestead) may be retained up to a maximum assessed value (less indebtedness) of \$5,000.</p> <p>Equity in non-income-producing property (non-homestead) may be retained up to a maximum assessed value (less indebtedness) of \$3,000.</p> <p>A burial reserve may be retained up to \$1000 for each family member in the form of cash surrender value of life insurance, prepaid burial, or a combination of both.</p> <p>The following personal property is exempt, regardless of value: Personal effects, household furnishings, an automobile, and farm equipment.</p> <p>In addition, liquid assets (cash, savings accounts, stocks, bonds, or other reserves readily convertible into cash) may be retained up to a value of \$500 for one person, \$1,000 for 2 persons, and \$1,500 for 3 or more persons.</p> <p>Eligibility is denied if resources are in excess of the foregoing and applicant is notified that he may reapply when holdings have been reduced to the level of the allowable maximums.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children under age 21 and for adult blind or permanently and totally disabled children whose impairment has caused continuous dependency since age 18.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>A monthly Identification Card is issued to all persons and families eligible for medical assistance except the medically needy with excess income. For such persons, the amount of income available is computed for a 3-month period, beginning with the first day of the month of application, and an Identification Card issued only after client presents substantiating evidence of the use of such excess income for medical needs prior to the end of the quarter; the Identification Card expires at the end of the quarter; client is advised that he may return for another in any subsequent quarter when medical needs again exceed income.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Division of Medical Assistance (medical assistance unit) is located in the Bureau of Public Assistance of the Department of Economic Security. The Director of the Division is assisted by a full-time Institutional Care Coordinator (MSW), a full-time Chief Social Work Consultant (MSW), and a part-time psychiatrist (MD). Liaison is maintained with the Office of Medical Assistance in the Department of Health. The Director (B.A., Medical Care Administrator) of the Office of Medical Assistance of the Department of Health is assisted by a full-time pharmacist, a physician, and 3 registered nurses, and has available the part-time services of a dentist.</p>
<b>2. Supervision of Statewide Operations</b>	<p>Responsibilities assigned to the Division of Medical Assistance include the monitoring of the health aspects of the program, which are administered by the State Department of Health under a statutory contractual agreement. Supervision of Statewide operations maintained by the Division of Field Services of the Department of Economic Security through direct line supervision of 71 field offices is primarily focused on eligibility aspects of the program.</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the "Advisory Council for Medical Assistance". It is composed of 11 members appointed by the Governor and two ex officio members (Commissioners of the Department of Economic Security and the Department of Health). Authority for the council is statutory.</p>

**D. Administration and Management (Continued)**

<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money-payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Health processes, and the State Department of Economic Security pays, all vendor claims for services provided to recipients under the program.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Kentucky as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 74.30.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from State General Funds appropriated biennially. Unobligated balance may not be carried over within the biennium but reverts to the general funds at the end of each fiscal year.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, the program must be curtailed or a special session of the legislature must be called to appropriate additional funds.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

LOUISIANA

**A. General Information**

<b>1. Legal Base</b>	Act No. 9 of 1966, amending and re-enacting Sub-Section A of Section 153 of Title 46 of the Revised Statutes of 1950.
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on July 1, 1966.
<b>3. Administrative Responsibility</b>	The State Department of Public Welfare is the single State agency with responsibility for administration of the program on a Statewide basis through 63 parish departments of public welfare.
<b>4. Historical Background</b>	Prior to July 1, 1966, the medical services provided under public assistance varied among the four categories. As early as 1951, vendor payments with Federal financial participation were used on a limited basis in AB, APTD, and AFDC for some services; and in 1957 the use of such payments was extended to OAA. However, inpatient hospital care was not included for any category until 1961, when it was added for OAA only. Concurrently, the State implemented a program of Medical Assistance for the Aged (a Federal-State program for persons age 65 or over who were not recipients of public assistance but met certain criteria of financial and medical need) to provide inpatient hospital care, nursing home care, prescribed drugs for nursing home patients, and physicians' services.
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only.
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all eligible individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older.</p> <p>Skilled nursing home services are provided only for persons 21 years of age or older.</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. Limited to 15 days per calendar year; extensions allowed only where removal from hospital would endanger life or threaten permanent impairment of health. No requirements for prior authorization except that approval by State agency is required for extensions beyond the 15 day limit. Payments made to public hospitals and to participating private hospitals. Reimbursement on basis of reasonable cost (Title XVIII formula for hospitals participating in Medicare; Welfare Gross RCC method for other hospitals). Claims for persons age 65 or older processed and paid by fiscal agent (Louisiana Hospital Service Inc.), who in turn bills the State Department of Public Welfare for reimbursable amount under Title XIX; all other claims processed and all other reimbursable amounts paid by State Department of Public Welfare.
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older in State institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older in State institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.
<b>2. Outpatient Hospital Services</b>	Provided. Excluding insulin shots, changing catheters, changing dressings, and any type of follow-up care. No requirements for prior authorization. Payments made to public hospitals and to participating private hospitals. Reimbursement on basis of reasonable cost. Claims for persons age 65 or older processed and paid by fiscal agent (Louisiana Hospital Service, Inc.); all other claims processed and paid by State Department of Public Welfare.

**B. Medical and Remedial Care and Services (Continued)**

<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. Diagnostic services limited to patients with a plan for "continuing medical care" approved by State Department. No limitation on X-ray services. Prior authorization not required for X-ray therapy. Payment made to independent pathology and X-ray laboratories meeting requirements for Medicare participation. Reimbursement on basis of usual and customary charges (as established Statewide) which are reasonable; may be exceeded when circumstances warrant. Claims for persons age 65 or older processed and paid by fiscal agent (Pan-American Life Insurance Co.); all other claims processed and paid by State Department of Public Welfare.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>         <b>b. In Institutions for Tuberculosis</b>   <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to persons age 21 or older. No other limitations. Prior authorization of local department of public welfare required. Reimbursement on basis of maximum monthly vendor payment established by State Department of Public Welfare for various nursing home classifications. Where recipient has income in excess of his personal needs allowance, the excess is applied to the nursing home monthly rate; this may or may not reduce the payment made by the Welfare Department. Supplemental payment by relative or other third party may be accepted by the nursing home up to maximum monthly "participation rate" established by State Department of Public Welfare for particular nursing home classification. Claims processed and paid by State Department of Public Welfare.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Not provided.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. Limited to services of Doctors of Medicine. (State law does not provide for licensure of osteopaths.) Visits in home, office, or skilled nursing home limited to one per month; provided only for persons residing in skilled nursing homes and for other persons with an approved plan for "continuing medical care". Visits to patients in hospital without surgery limited to 5 per admission, within total limit of 15 per calendar year. Physician services for patients hospitalized with surgery limited to those rendered by operating surgeon (payment for surgery includes pre-operative and post-operative care during hospitalization). In addition, emergency care allowed for injuries due to accident (e.g., fractures or lacerations). No requirements for prior authorization, except for emergency care, which requires approval of local welfare office for costs up to \$25 (combined total for physician's services and drugs), and approval of State office where costs exceed \$25. Reimbursement on basis of usual, customary, and reasonable or prevailing charges established Statewide (California Relative Value Scale is used, with conversion factor of 6). Claims for persons age 65 or older processed and paid by fiscal agent (Pan-American Life Insurance Co.); all other claims processed and paid by State Department of Public Welfare.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>  <b>b. Optometrists</b>  <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Not provided.</p> <p>Not provided.</p> <p>[Except: Payment is made for cataract glasses or contact lenses following cataract surgery.]</p> <p>Not provided.</p> <p>Not provided.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing services. Not provided.</p> <p>(b) Services of home health aide. Not provided.</p> <p>(c) Medical supplies, equipment, and appliances. Appliances only; provided on a limited basis. Prior authorization of local parish office required for items costing \$25 or less; of State Department of Public Welfare for items costing over \$25. Reimbursement on basis of established payment rates used by Veteran's Administration. Claims for persons age 65 or older processed and paid by fiscal agent, who in turn bills the State Department of Public Welfare for amount reimbursable under title XIX; all other claims processed and all other reimbursable amounts paid by State Department of Public Welfare.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	<p>Not provided.</p> <p>[For Rehabilitation Center Services, see Item B. 20.]</p>
<b>11. Dental Services</b>	Not provided.
<b>12. Physical Therapy and Related Services</b>	<p><b>a. Physical Therapy</b></p> <p>Not provided.</p> <p>[For such services in Rehabilitation Center, see Item B. 20.]</p> <p><b>b. Occupational Therapy</b></p> <p>Not provided.</p> <p><b>c. Speech Therapy</b></p> <p>Not provided.</p> <p>[For such services in Rehabilitation Center, see Item B. 20.]</p> <p><b>d. Audiology</b></p> <p>Not provided.</p> <p>[For such services in Rehabilitation Center, see Item B. 20.]</p>
<b>13. Prescribed Drugs</b>	<p>Provided. Limited to life-saving and essential drugs (both legend and non-legend) listed on Department drug schedule. Provided for persons receiving emergency care for injuries due to accident (i.e., fractures or lacerations), for persons with an approved plan for "continuing medical care", and for persons in skilled nursing homes. Prior approval of State Department required for certain drug items. Payments made to pharmacies and to dispensing physicians whose office is more than 5 miles from drug store or other dispensing facility. Also, reimbursement of State Department of Hospitals for prescribed medications dispensed to recipients who are receiving services through a mental outpatient facility of the Department of Hospitals; no reimbursement for medications prescribed by such facility but purchased elsewhere. Reimbursement on basis of wholesale cost plus 50%; additional 50¢ where wholesale cost is less than \$5; additional \$1 for compound prescriptions; insulin and catheters limited to wholesale cost plus 50%; \$1 minimum prescription charge permitted, within overall prohibition against billings exceeding charges to general public. Claims processed and paid by State Department of Public Welfare.</p>
<b>14. Prosthetic Devices</b>	<p><b>a. Eyeglasses</b></p> <p>Not provided.</p> <p>[Except: Payment is made for cataract glasses or contact lenses following cataract surgery.]</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Hearing Aids</b>	Provided. Only when recommended by ear specialist. Prior approval of State Department of Public Welfare, including approval of auditory training plans, required. Reimbursement on basis of fee schedule. Claims for persons age 65 or older are processed and paid by fiscal agent, who bills State Department of Public Welfare for amount reimbursable under title XIX; all other claims processed and all other reimbursable amounts paid by State Department of Public Welfare.
<b>c. Dentures</b>	Not provided.
<b>d. Other Prosthetic Devices</b>	Provided. Artificial eyes, limbs, braces and other prosthetic devices or appliances recommended by appropriate medical authority. Prior authorization of local parish office required for items costing \$25 or less; of State Department of Public Welfare for items costing over \$25. Reimbursement on basis of fee schedule. Claims for persons 65 or older processed and paid by fiscal agent, who bills State Department of Public Welfare for amount reimbursable under title XIX; all other claims processed and paid by State Department of Public Welfare.
<b>15. Family Planning Services</b>	Not provided.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Limited to 15 days per calendar year (including any days of non-emergency inpatient hospital care received). Authorization of payment by State Department of Public Welfare required. Reimbursement on basis of 85% of billed charges. Claims for persons 65 or older processed and paid by fiscal agent, who bills State Department of Public Welfare for amount reimbursable under title XIX; all other claims processed and paid by State Department of Public Welfare.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. Limited to rehabilitation services furnished in public or private Rehabilitation Center under an individual plan of services recommended by the Center. Approval of plan of services by Commissioner of Public Welfare (with advice of the Division of Medical Services) required. Reimbursement on basis of negotiated fee. Claims processed and paid by State Department of Public Welfare.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Not provided.
<b>b. Other</b>	Not provided.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility, an individual is retroactively entitled to inpatient hospital services and physicians' services while in hospital beginning with the first day of the third month prior to the month of application, and to other medical services provided under the program as early as the first day of the month in which application is made; provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C. 3. a.;



## C. Eligibility for Medical Assistance (Continued)

a. Under Age 21	<p>(1) Child deprived of parental support or care, living with a parent or caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(3) Child in foster home or private institution for whom State Department of Public Welfare is assuming financial responsibility in whole or in part. [Including non-AFDC foster care.]</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition), if age 18 or older.</p> <p>(6) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p>
b. Age 21 to 64	<p>(1) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. [Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.]</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p>
c. Age 65 or older	<p>(1) Individual who is 65 or older.</p>
3. Coverage of the Categorically Needy	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative cost:</p>
a. FFP Claimed in Medical and Administrative Costs	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC program but who would be eligible for such assistance if they left the facility.</p> <p>(5) Children in foster homes and private institutions for whom the State Department of Public Welfare is assuming financial responsibility in whole or in part.</p> <p>(6) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p>
b. FFP Claimed in Administrative Costs Only	<p>None.</p>
4. Coverage of the Medically Needy	<p>Not included.</p>
5. Financial Criteria	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p>
a. For Categorically Needy Persons	<p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>
b. For Medically Needy Persons	<p>[Not applicable.]</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children under age 21 and adult children who are blind or permanently and totally disabled.
<b>7. Identification to Vendors of Persons Eligible</b>	A Hospital Identification Card is issued to all persons certified eligible. A Medical Identification Card (for physicians' calls in home or office, clinic visits, and drugs) is issued to eligible persons with an approved plan for "continuing medical care" and for eligible persons in skilled nursing homes.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Division of Medical Services (medical assistance unit) is one of three operating divisions under the Director of Services to Children and Families, whose office is in the organizational echelon directly under the Commissioner of Public Welfare. Full-time professional staff of the Division consists of a Director (M.D.), a clinical social worker (MSW), a psychiatric social worker (MSW), and 5 administrative social workers (including 3 MSW's). Services of 14 consulting physicians and surgeons are also available on a part-time basis. Other professional staff assigned outside the Division, but available on a part-time basis when needed, are a consulting pharmacist, an ophthalmologist, and a clinical social worker.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations maintained by the Division of Assistance Payments and Services through staff in 63 parish departments of public welfare is primarily focused on eligibility aspects of the program. Consultation with the Medical Director and/or appropriate staff of the Division of Medical Services is available Statewide as needed.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the "Medical Advisory Council". It is composed of 27 members appointed by the Commissioner of Public Welfare. There are no ex officio members. Authority for the council is administrative.
<b>4. Buy-In Agreement</b>	None.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Public Welfare processes and pays all vendor claims for services provided under the program to persons under age 65. Fiscal agent processes and pays all vendor claims for services provided to persons age 65 or older and bills the State Department of Public Welfare for the amount reimbursable under title XIX.
<b>b. Fiscal Agents</b>	The State Department of Public Welfare has entered into two fiscal agent contracts for the processing and payment of certain claims for services provided to recipients age 65 or older: (1) Contract with Louisiana Hospital Service, Inc. (Blue Cross). Provides that fiscal agent shall receive, process, and pay all claims for inpatient hospital services and certain other services provided to eligible persons age 65 or older and bill State Department of Public Welfare for the amount reimbursable under title XIX. (2) Contract with Pan-American Life Insurance Company (Blue Shield). Provides that fiscal agent shall receive, process, and pay claims for services provided by physicians and by independent laboratories to persons age 65 or older which are reimbursable under the program.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.



**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Louisiana as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 73.57.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from earmarked funds made available through annual legislative appropriation of a specific amount for all public assistance programs, including but not specifically allocating the amount for financing of the medical assistance program. Unobligated balance may not be carried over to the next fiscal year.
<b>4. Deficit Financing</b>	State law prohibits deficit spending. When needed before the next appropriation period, additional funds can be made available by approval of the Board of Liquidation of the State Debt, followed by a poll of legislators by the State Comptroller and approval by a majority of both Houses.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health and Welfare

January 1, 1970

MAINE

**A. General Information**

<b>1. Legal Base</b>	Maine Revised Statutes Annotated (1964), Title 22, Sections 3301-3453.
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on November 15, 1966.
<b>3. Administrative Responsibility</b>	The Department of Health and Welfare is the single State agency with responsibility for administration of the program through a system of seven district welfare offices.
<b>4. Historical Background</b>	Prior to July 1, 1966, medical services provided for public assistance recipients through vendor payments were limited to inpatient hospital services (all categories) and nursing home care (AABD and child or incapacitated parent, if he was caretaker, in AFDC). Payment for services rendered was made through a pooled fund, in effect since the beginning of the program in July 1955, into which a monthly premium was paid for each recipient on the assistance rolls. In October, 1961, on the basis of newly enacted legislation, a program of Medical Assistance for the Aged (MAA) was instituted (a Federal-State program for persons age 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need). Services under the MAA program were limited to hospital care, home health care (provided by a Visiting Nurse Association), and comprehensive clinic services. Because of limited appropriations, medical care provided under the public assistance and MAA programs did not represent full implementation of existing legislative authority.
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only.
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all eligible individuals with the following exceptions:</p> <p>Services for persons in institutions for mental diseases are provided only for patients who are 65 years of age or older.</p> <p>Early and periodic screening and diagnosis to ascertain physical or mental defects, etc., is provided only for individuals under the age of 21.</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. No limitations. Prior authorization required for extensions beyond 90 days and for out-of-State services not available in Maine. Reimbursement on basis of reasonable cost. Claims reviewed and determination of reasonable cost made by fiscal agent (Associated Hospital Service of Maine); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of claims for other amounts not reimbursable under Medicare made by State Department of Health and Welfare.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older in public and private institutions for mental diseases. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims reviewed and determination of reasonable cost made by fiscal agent (Associated Hospital Service of Maine); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of claims for other amounts not reimbursable under Medicare made by State Department of Health and Welfare.



**B. Medical and Remedial Care and Services (Continued)**

2. Outpatient Hospital Services	Provided. No limitations. Prior authorization required only for out-of-State services not available in Maine. Reimbursement on basis of reasonable cost. Claims reviewed and determination of reasonable cost made by fiscal agent (Associated Hospital Service of Maine); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of claims for other amounts not reimbursable under Medicare made by State Department of Health and Welfare.
3. Other Laboratory and X-ray Services	Provided. No limitations. No requirements for prior authorization. Payments made to pathologists, radiologists, and independent laboratories which are certified for Medicare. Reimbursement on basis of usual and customary charge. Claims reviewed and determination of reasonable charge made by fiscal agent (Union Mutual Life Insurance Company); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of claims for other amounts not reimbursable under Medicare made by State Department of Health and Welfare.
4. Skilled Nursing Home Services	
a. General	Provided. For persons of all ages. In State-licensed homes which are certified for Medicare as extended care facilities. No limitations. No requirements for prior authorization; decision by district evaluation team as to need for this level of care and authorization by assistance payments worker may be made before or after admission to home. Reimbursement on basis of reasonable cost. Claims reviewed and determination of reasonable cost made by fiscal agent (Associated Hospital Service of Maine); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of claims for other amounts not reimbursable under Medicare made by State Department of Health and Welfare.
b. In Institutions for Tuberculosis	Not provided.
c. In Institutions for Mental Diseases	Provided. Limited to persons age 65 or older in public and private institutions for mental diseases. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims reviewed and determination of reasonable cost made by fiscal agent (Associated Hospital Service of Maine); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of claims for other amounts not reimbursable under Medicare made by State Department of Health and Welfare.
5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
6. Physicians' Services (M.D. and D.O.)	Provided. No limitations. Prior authorization required for out-of-State services not available in Maine. Reimbursement on basis of usual and customary charges. Claims reviewed and determination of reasonable charges made by fiscal agent (Union Mutual Life Insurance Co.); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of other amounts not reimbursable under Medicare made by State Department of Health and Welfare.
7. Services of Licensed Practitioners	
a. Podiatrists	Provided. Limited to non-routine procedures. No requirements for prior authorization. Reimbursement for services to Medicare beneficiaries on basis of reasonable charges; for others, on basis of negotiated rate. Claims reviewed and determination of reasonable charges made by fiscal agent (Union Mutual Life Insurance Co.); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of claims for other amounts not reimbursable under Medicare made by State Department of Health and Welfare.
b. Optometrists	Not provided.
c. Chiropractors	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>d. Other</b>	Services of clinical psychologists: Provided. Limited to psychometric testing, when recommended by a physician or a social worker of the State agency. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Health and Welfare.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided if furnished by a Home Health Agency certified for Medicare. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims reviewed and determination of reasonable cost made by fiscal agent (Union Mutual Life Insurance Co.); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of other amounts not reimbursable under Medicare made by State Department of Health and Welfare.</p> <p>(b) Services of home health aide. Provided if furnished by a Home Health Agency certified for Medicare. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims reviewed and determination of reasonable cost made by fiscal agent (Union Mutual Life Insurance Co.); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of other amounts not reimbursable under Medicare made by State Department of Health and Welfare.</p> <p>(c) Medical supplies, equipment, and appliances. Provided if prescribed by physician. Prior authorization required for appliances. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Health and Welfare.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Provided. Limited to patients in hospitals and skilled nursing homes. No other limitations. Prior authorization required. Payment only for services billed by hospital or nursing home. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Health and Welfare.
<b>10. Clinic Services (Other than Hospital)</b>	Provided. In physician-directed clinics certified for Medicare. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims reviewed and determination of reasonable cost made by fiscal agent (Union Mutual Life Insurance Co.); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of other amounts not reimbursable under Medicare paid by State Department of Health and Welfare.
<b>11. Dental Services</b>	<p>Not provided.</p> <p>[However, payments are made to dentists for services of the limited type covered under Medicare, e.g., services involving surgery of the jaw or related structures, or setting of fractures of the jaw or facial bones.]</p>
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. No limitations. No requirements for prior authorization. Payments made only to hospitals, skilled nursing homes, and home health agencies qualified under Medicare. Reimbursement on basis of reasonable cost. Medicare coinsurance and deductible paid by fiscal agent (Union Mutual Life Insurance Co.); final processing and payment of other amounts not reimbursable under Medicare paid by State Department of Health and Welfare.
<b>b. Occupational Therapy</b>	Provided. No limitations. No requirements for prior authorization. Payments made only to hospitals, skilled nursing homes, and home health agencies qualified under Medicare. Reimbursement on basis of reasonable cost. Medicare coinsurance and deductible paid by fiscal agent (Union Mutual Life Insurance Co.); final processing and payment of other amounts not reimbursable under Medicare paid by State Department of Health and Welfare.



**B. Medical and Remedial Care and Services (Continued)**

c. Speech Therapy	Provided. No limitations. No requirements for prior authorization. Payments made only to hospitals, skilled nursing homes, and home health agencies qualified under Medicare. Reimbursement on basis of reasonable cost. Medicare coinsurance and deductible paid by fiscal agent (Union Mutual Life Insurance Co.); final processing and payment of other amounts not reimbursable under Medicare paid by State Department of Health and Welfare.
d. Audiology	Not provided.
13. Prescribed Drugs	Provided. Legend drugs only, excluding combinations of antibiotics and most sedatives and hypnotics. Non-maintenance drugs limited to 30-day supply with no refill. Maintenance drugs limited to 90-day supply with refills ordered by physician. Prior authorization required for prescription over \$10.00. Licensed pharmacists are reimbursed at wholesale cost plus professional fee. (Hospitals and skilled nursing homes are reimbursed for drugs provided to inpatients.) Claims processed and paid by State Department of Health and Welfare.
14. Prosthetic Devices	
a. Eyeglasses	Provided. Limited to first pair following eye surgery. No requirements for prior authorization. Reimbursement to ophthalmologist on basis of cost plus professional fee; to optician on basis of cost plus mark-up. Claims processed and paid by State Department of Health and Welfare.
b. Hearing Aids	Not provided.
c. Dentures	Not provided.
d. Other Prosthetic Devices	<p>Provided as follows:</p> <p>(1) Prosthetic devices (other than dental) which replace all or part of an internal body organ, including replacement of device.</p> <p>(2) Artificial limbs and eyes, including replacements; also leg, arm, back, and neck braces.</p> <p>No limitations. Prior authorization required. Reimbursement on basis of usual and customary charges. Claims reviewed and determination of reasonable charges made by fiscal agent (Union Mutual Life Insurance Co.); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of other amounts not reimbursable under Medicare paid by State Department of Health and Welfare.</p>
15. Family Planning Services	Provided. Including drugs, supplies, and devices. No limitations, but services must be rendered under supervision of a physician. No requirements for prior authorization. Reimbursement to physicians on basis of usual and customary charges; to hospital and clinic on basis of reasonable cost. Claims processed and paid by State Department of Health and Welfare.
16. Services of Christian Science Nurses	Not provided.
17. Care and Services in Christian Science Sanatoria	Not provided.
18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)	Provided. In State-licensed hospitals only. No limitations. Prior authorization required when practicable. Reimbursement on basis of reasonable cost. Claims reviewed and determination of reasonable cost made by fiscal agent (Associated Hospital Service of Maine); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of claims for other amounts not reimbursable under Medicare made by State Department of Health and Welfare.
19. Personal Care Services In Patient's Home	Not provided.
20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services	Provided. No limitations. Prior authorization required. Reimbursement on basis of usual and customary charge. Claims received and determination of reasonable charges made by fiscal agent (Union Mutual Life Insurance Co); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of other amounts not reimbursable under Medicare made by State Department of Health and Welfare.

**B. Medical and Remedial Care and Services (Continued)**

<b>21. Transportation</b>  <b>a. Ambulance</b>          <b>b. Other</b>	<p>Provided. Including essential attendant (RN or LPN). No limitations, but service must be prescribed by physician. No requirements for prior authorization. Payment made to qualified ambulance services which are Medicare-certified. Payment for attendant only if billed by ambulance service. Reimbursement on basis of usual and customary charges. Claims reviewed and determination of reasonable charge made by fiscal agent (Union Mutual Life Insurance Co.); Medicare coinsurance and deductible paid by fiscal agent; final processing and payment of other amounts not reimbursable under Medicare made by Department of Health and Welfare.</p> <p>Not provided.</p>
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**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month in which application was made, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>  <b>a. Under Age 21</b>          <b>b. Age 21 to 64</b>          <b>c. Age 65 or older</b>	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p> <p>(1) Child deprived of parental support or care, living with a parent or caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of a father.</p> <p>(2) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(3) Child in foster home or private institution for whom a public agency is assuming financial responsibility. [Including non-AFDC foster care]</p> <p>(4) Person who is blind (State definition) and age 16 or older.</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(6) Essential spouse [title XIX definition] of an AABD recipient.</p> <p>(1) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of an AABD recipient.</p> <p>(1) Person who has attained age 65.</p>
<b>3. Coverage of the Categorically Needy</b>          <b>a. FFP Claimed in Medical and Administrative Costs</b>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of AABD and AFDC.</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program of medical assistance under title XIX.</p> <p>(3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p>



**C. Eligibility for Medical Assistance (Continued)**

<p>a. FFP Claimed in Medical and Administrative Costs</p>	<p style="text-align: center;"><i>Optional</i></p> <p>(4) Parents or caretaker relatives (as specified in the State's AFDC plan) with whom dependent children described in Item C.3.a.(3), above, are living.</p> <p>(5) Children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part.</p> <p>(6) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC programs but who would be eligible for such assistance if they left the institution.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of AABD.</p>
<p>b. FFP Claimed in Administrative Costs Only</p>	<p>None.</p>
<p>4. Coverage of the Medically Needy</p>	<p>Not included.</p>
<p>5. Financial Criteria</p> <p>a. For Categorically Needy Persons</p> <p>b. For Medically Needy Persons</p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>Not applicable.</p>
<p>6. Financial Responsibility of Relatives</p>	<p>The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse (if living together), and of parents for children under age 21.</p>
<p>7. Identification to Vendors of Persons Eligible</p>	<p>A Medical Identification Card is issued each month to all persons certified as eligible for medical assistance.</p>

**D. Administration and Management**

<p>1. Medical Assistance Unit</p>	<p>The Bureau of Medical Care (medical assistance unit) of the Department of Health and Welfare is headed by a Director (M.D.), who is directly responsible to the Commissioner of Health and Welfare. In addition to the Director, the full-time professional staff of the Bureau consists of a Medical Social Administrator (social worker), a Medical Social Consultant (social worker), a Psychiatric Social Worker, a Nurse Education Consultant (RN), a Pharmacist, and a liaison Social Worker for Mental Health. Available on a part-time basis are the services of a Dental Consultant (D.D.S.) and a Psychiatric Consultant (psychiatrist).</p>
<p>2. Supervision of Statewide Operations</p>	<p>Supervision of Statewide operations is accomplished through the activities of 2 field supervisors (one Assistance payments, and one Child and Family Services) and 10 part-time physician consultants (one in each of 7 district offices, and 3 at-large).</p>
<p>3. Advisory Council</p>	<p>The State advisory body for title XIX is known as the Title XIX Advisory Committee. The Committee is composed of 24 members appointed by the Commissioner of Health and Welfare, and has in addition 7 ex officio members (Commissioner of Health and Welfare, Director of the Bureau of Medical Care, Director of the Bureau of Social Welfare and the Directors of the Divisions of Adult and Family Services, Child and Family Services, Child Health, and Public Health Nursing). Selection of the chairman is by vote of the membership. Authority for the Committee is administrative.</p>

**D. Administration and Management (Continued)**

<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all persons age 65 or older who are eligible for benefits under both title XVIII of the Social Security Act and the State's program under title XIX.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Health and Welfare processes all vendor claims except those for services within the scope of the Medicare program provided to persons age 65 or older, which are handled by the Department's fiscal agents; pays all claims except for amounts due as deductibles or coinsurance for services provided to Medicare beneficiaries, which are paid by State's fiscal agents.
<b>b. Fiscal Agents</b>	State has entered into fiscal agent contracts with the following organizations: (1) Associated Hospital Service of Maine (Blue Cross). Reviews claims for services provided by hospitals, extended care facilities, and home health agencies, determines reasonable costs, and pays amounts due as deductible or coinsurance. (2) Union Mutual Life Insurance Company. Reviews claims for all services included within the scope of Medicare Supplementary Medical Insurance program, determines reasonable charges, and pays amounts due as deductible or coinsurance.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Maine as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 68.33.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs are derived from appropriations from State General Funds. Appropriations are made annually; unobligated balance may be carried over to next fiscal year.
<b>4. Deficit Financing</b>	When additional funds are needed to meet a deficit before the next appropriation period, the Governor and the Executive Council may make an emergency appropriation.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health

January 1, 1970

MARYLAND

**A. General Information**

<b>1. Legal Base</b>	Article 43, Sections 1B and 42(a), respectively, Annotated Code of Maryland.
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on August 12, 1966.
<b>3. Administrative Responsibility</b>	<p>The Department of Health of the State Department of Health and Mental Hygiene serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices.</p> <p>The State Department of Social Services is responsible for the determination of eligibility for medical assistance.</p>
<b>4. Historical Background</b>	<p>As early as 1945, the Maryland Medical Care program had been authorized by the General Assembly to enter into agreements with various vendors of medical services. In 1958, after the Social Security Act was amended to liberalize the Federal financial participation in vendor payments for such services, the Federal agency approved a plan of the Maryland Department of Welfare which provided for making vendor payments under the public assistance categories for a Statewide program for all public assistance recipients. The services were made available primarily through a contract between the Welfare Department and the Health Department. The program provided a comprehensive range of services with few limitations except that inpatient hospital care was limited to 21 days with extensions only when medically justified. In 1961, based on existing statutory authority, a Federal-State program of Medical Assistance for the Aged (MAA) was instituted providing medical care for persons age 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need. Except for the exclusion of nursing home care, services provided under the MAA program closely paralleled those provided to public assistance recipients.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (See Item B.1.b. and c, and B.4.b. and c.)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (See Item B.4.a.)</p> <p>Inpatient hospital services are made available on a more limited basis to medically needy persons than to categorically needy persons. (See Item B.1.a.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	<p>Provided. Unlimited for categorically needy persons. Limited to 21 days per admission for medically needy persons. A maximum of 14 days care for services provided is authorized upon notification of admission; approval of State office required for extension beyond 14 days. A single extension of care is limited to a maximum of 14 days; additional extensions may be authorized. Reimbursement on basis of reasonable cost. Claims for services rendered to persons under age 65 processed by State Department of Health, and certified to State Comptroller's Office for payment; for older persons, processed and paid by fiscal agent (Maryland Hospital Service).</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older who are patients in State institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of audited cost of care. Claims processed by Division of Reimbursements, State Department of Mental Hygiene, paid through State administrative procedure.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older who are patients in State institutions. Not provided in private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of audited cost of care. Claims processed by Division of Reimbursements, State Department of Mental Hygiene; paid through State administrative procedure.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed by State Department of Health; and certified to State Comptroller's Office for payment.
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. Doctor's order required. Reimbursement on basis of fee schedule established within budgetary limitations. Claims processed by State Department of Health; and certified to State Comptroller's Office for payment.
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. Limited to persons age 21 or older. No other limitations. Prior authorization required from State and/or local Health Department, based on medical evaluation of applicant. Reimbursement on basis of agreed audited fee within limits established by State legislature. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older who are patients in State institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of audited cost of care. Claims processed by Division of Reimbursements, State Department of Mental Hygiene, paid through State administrative procedure.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older who are patients in State institutions. Not provided in private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of audited cost of care. Claims processed by Division of Reimbursements, State Department of Mental Hygiene paid through State administrative procedure.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule within budgetary limitations. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Limited to services given on physician's order for patients in nursing homes. No other limitations. No requirements for prior authorization. Considered as part of nursing home cost.
<b>b. Optometrists</b>	Provided. No limitations, except that medically needy persons in non-Federal category are eligible only after cataract surgery. Prior authorization required from local office. Reimbursement on basis of fee schedule. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided when furnished by a home health agency and when prescribed by patient's physician. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.</p> <p>(b) Services of home health aide. Provided when furnished by a home health agency and prescribed by patient's physician. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. Limited to certain items for use in patient's home and nursing homes. Items with cost of \$5.00 or more require prior authorization from local health office. Reimbursement on basis of cost plus 50% or usual retail price, whichever is less. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Not provided.</p> <p>[Provided free in Health Department clinics; not paid for under Medical Assistance Program.]</p>
<b>11. Dental Services</b>	<p>Provided. General dental services. Orthodontia not included. No other limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.</p>
<b>12. Physical Therapy and Related Services</b>	<p><b>a. Physical Therapy</b></p> <p>Provided. Limited to therapy given on physician's order in patient's own home or in therapist's office. No other limitations. No requirements for prior authorization. Reimbursement on basis of established fee. [If provided to patients in skilled nursing home, included in nursing home cost.] Claims processed by State Department of Health and certified to State Comptroller's Office for payment.</p> <p><b>b. Occupational Therapy</b></p> <p>Provided. When furnished by a home health agency in conformance with a physician's plan of treatment. No requirements for prior authorization. Reimbursement on basis of reasonable cost. [If provided to patient in skilled nursing home, included in nursing home cost.] Claims processed by State Department of Health and certified to State Comptroller's Office for payment.</p> <p><b>c. Speech Therapy</b></p> <p>Provided. When furnished by a home health agency in conformance with a physician's plan of treatment. No requirements for prior authorization. Reimbursement on basis of reasonable cost. [If provided to patient in skilled nursing home, included in nursing home cost.] Claims processed by State Department of Health and certified to State Comptroller's Office for payment.</p> <p><b>d. Audiology</b></p> <p>Not provided.</p>
<b>13. Prescribed Drugs</b>	<p>Provided. Legend and non-legend drugs. No limitations but prescriptions with ingredient-cost in excess of \$10 require prior authorization. Reimbursement on basis of wholesale cost plus professional fee. Over-the-counter preparations ordered by the physician or dentist reimbursed on basis of cost plus 50% or the pharmacy's usual price, whichever is less. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. No limitations, except that medically needy persons in non-Federal matching category are eligible for eyeglasses only after cataract surgery. Prior authorization from local office required. Reimbursement on basis of cost of lenses plus agreed fees. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.
<b>b. Hearing Aids</b>	Not provided.
<b>c. Dentures</b>	Provided. No limitations. Prior authorization from local office required. Reimbursement on basis of fee schedule. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.
<b>d. Other Prosthetic Devices</b>	Provided. Prosthetic appliances when furnished by hospital or by others under arrangement with hospital for inpatient care; also, trusses and post-operative abdominal supports, where surgery is contraindicated. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.
<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices. No limitations. No requirements for prior authorization. Reimbursement of physicians on basis of fee schedule; of pharmacists on basis of wholesale cost plus professional fee. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. When medically necessary to prevent death or serious impairment to health, and until patient can safely be moved to a qualified hospital. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims for services rendered to persons under age 65 processed by State Department of Health and certified to State Comptroller's Office for payment; for older persons, processed and paid by fiscal agent (Maryland Hospital Service).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. Limited to other diagnostic and rehabilitative services. "Other diagnostic services" provided without limitations, but must be ordered by physician. "Other rehabilitative services", as provided by State Division of Vocational Rehabilitation, with no requirements for prior authorization. Reimbursement on basis established for each type of provider utilized. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. Limited to non-emergency, non-ambulatory cases being admitted to or discharged from a hospital or being transported to or from the outpatient facilities of a hospital. Hospitals authorize ambulance transportation based on a request by a physician. Reimbursement on basis of fee schedule within budgetary limitations. Claims processed by State Department of Health and certified to State Comptroller's Office for payment.
<b>b. Other</b>	Not provided.



### C. Eligibility for Medical Assistance

1. Date of Entitlement	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
2. Conditions of Eligibility (By Age Groups)	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
	(1) Individual under age 21.
	(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father. (If child does not meet State's AFDC plan requirements regarding age and school attendance, eligibility of caretaker with whom child is living is limited to parent and spouse of the parent.) (2) Person who is blind (State definition). (3) Person who is permanently and totally disabled (State definition). (4) Essential spouse [title XIX definition] of a recipient of AABD.
	(1) Individual who has attained age 65.
3. Coverage of the Categorically Needy	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
	<p style="text-align: center;"><i>Mandatory</i></p> (1) Recipients of AABD and AFDC. (2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX. (3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan. <p style="text-align: center;"><i>Optional</i></p> (4) Persons eligible for but not receiving AABD or AFDC. (5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC programs but who would be eligible for such assistance if they left the facility. (6) The parents or caretaker relative with whom a child described in Item C.3.a.(3), above, is living. (7) All individuals under age 21. (8) Essential spouse [title XIX definition] of a recipient of AABD. (Categorically needy only)
	<p style="text-align: center;"><i>Optional</i></p> (1) All other individuals and families whose resources are insufficient to pay for the medical and remedial care and services provided under the plan.

### C. Eligibility for Medical Assistance (Continued)

<b>4. Coverage of the Medically Needy</b>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Items C.3.a. and b., above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.</p>
<b>5. Financial Criteria</b>  <b>a. For Categorically Needy Persons</b>  <b>b. For Medically Needy Persons</b>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>(1) <i>Income</i>  Annual income which may be retained for basic maintenance needs: \$1800 for one person, \$2280 for family of 2, \$2700 for 3, \$3100 for 4, \$3600 for 5, and \$400 for each additional person dependent upon the income.</p> <p>[Note: Federal financial participation is not claimed in the first \$300 of costs of medical care for a family of one, the first \$180 for a family of 2, or the first \$100 for a family of 3.]</p> <p>Person in chronic (long-term) care in a medical facility may retain \$10 a month for personal expenses. Additional income may be retained for expenses necessary to maintain a home to which the patient plans to return. No income may be retained for maintenance of spouse.</p> <p>(2) <i>Resources</i>  Home in which an individual lives or to which he plans to return is exempt regardless of value.</p> <p>Other real property may be retained if income-producing, but if non-income-producing it is considered as an asset convertible to cash and must be put up for sale.</p> <p>The following personal property may be retained regardless of value: Clothing and personal effects; household furnishings and appliances; an automobile, if needed for necessary transportation; and personal property needed for employment or for maintaining home.</p> <p>Cash and other assets convertible to cash, such as savings account, stocks, bonds, cash value of life insurance, and market value of non-home non-income-producing real property may be retained up to \$2500 for one person, \$2600 for two persons, plus \$100 for each additional person.</p> <p>Resources in excess of these amounts render an individual ineligible until such time as excess is in fact spent or obligated for medical expenses.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited as follows: Husband for wife; wife for cost of care of husband who is in a chronic or mental hospital; and parent for minor child, unless such child is married, or is an unmarried pregnant girl age 18 to 21 who is living apart from her parents and receiving services from a public or private agency.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>A Medical Care Card is issued to eligible individuals and families at time of certification and recertification. Green cards bearing code letter "N" are issued to categorically needy persons; pink cards bearing code letter "P" are issued to medically needy persons. An identification card will not be issued to medically needy persons with excess income except in the following circumstances: Where individual needs hospitalization or long-term care in a medical institution and estimated medical needs exceed excess income and resources available during a 6-month period, a Medical Care Card will be issued showing monthly amount of medical costs for which recipient is held responsible, i.e., amount for which the State Department of Health will not assume responsibility.</p>



**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Chief of the Division of Medical Services (medical assistance unit) reports to the Assistant Commissioner for Medical Care Services (M.D.), an organizational unit directly under the office of the Commissioner of Health. In addition to the Chief (Hospital Administration), full-time professional staff of the Division consists of an Assistant Chief (Business Administration), a Medical Consultant (M.D.), a Drug Consultant, a Hospital Advisor (R.N.), 5 Program Analysts (degrees in various fields), and a Social Worker (MSW). Services of the following professional staff are available on a part-time basis: a Dental Consultant, 3 Physician Consultants, and a Psychiatrist Consultant. In addition, the following personnel employed elsewhere in the Department are available as needed: 5 Physicians and 1 Dentist.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through a system of local offices (local Health offices and local Social Services offices) which are reasonably accessible to persons in all parts of the State. State staff is available for consultation and for visits to local offices to interpret State policies and to assure that they are carried out. Local Health Offices are responsible, based on State policies, for such things as preauthorizations, medical evaluations and re-evaluations of skilled nursing home patients, and, in some cases, for studying and making preliminary investigations of possible over-utilization and fraud cases. Regular field staff of the Department of Social Services provide consultation and supervision to the county offices on matters of eligibility and related services.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Assistance Advisory Committee. It is composed of 31 members appointed by the Secretary of Health and Mental Hygiene. Authority for the Committee is administrative.
<b>4. Buy-In Agreement</b>	None.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Health receives, processes, and certifies to the State Comptroller's Office for payment all medical vendor claims except those for services provided by general hospitals for persons age 65 or older. Claims for services provided by institutions for tuberculosis and mental diseases are processed by Division of Reimbursements, State Department of Mental Hygiene, and paid through State administrative procedure.
<b>b. Fiscal Agents</b>	State has entered into a fiscal agent contract with Maryland Medical Services, Inc. (Blue Cross) under which the fiscal agent processes and pays all claims received from general hospitals for services provided to recipients age 65 or older.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Maryland as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.
<b>2. State/Local Participation</b>	State funds are used to pay 93.7% of the non-Federal share of program costs of medical assistance, and 98% of costs of administration. The remaining portion of the non-Federal share is paid out of funds placed on deposit with the State Department of Health by each county and Baltimore City for the sole purpose of paying for inpatient hospital care for their residents.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually. Unobligated balance reverts to the General Fund at the end of each fiscal year.
<b>4. Deficit Financing</b>	If additional financing is needed before the next appropriation period, unobligated funds in other parts of the budget may be made available with the approval of the Budget Bureau and the Governor, or a deficiency appropriation may be requested from the State Legislature.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare  
Commission for the Blind

January 1, 1970

MASSACHUSETTS

### A. General Information

1. Legal Base	Chapter 874, Acts of 1965, Chapter 535, Acts of 1966, and Chapter 800, Acts of 1969.
2. Beginning Dates	Program went into operation on September 1, 1966. Original plan approved by the Federal agency on October 7, 1966.
3. Administrative Responsibility	There are two agencies, each with responsibility for administering a medical assistance program on a Statewide basis: (1) The Department of Public Welfare (OAA, APTD, and AFDC) with its local Community Service Centers, and (2) the Commission for the Blind (AB) with no local agencies. Medical services in institutions for mental diseases (inpatient hospital care and skilled nursing home care), which are restricted by Federal law to patients over the age of 65, are provided in the medical assistance plan under the administration of the State Department of Public Welfare.
4. Historical Background	<p>Payments to the suppliers of medical care with Federal financial participation under the public assistance categories have been used by the Department of Public Welfare since the autumn of 1951 for recipients of OAA, APTD, and AFDC. The Division of the Blind in the Department of Education (now the State Commission for the Blind) first used such payments under its AB program in 1957. By 1961, the two programs together provided a comprehensive scope of medical care and services to recipients under all programs, except that under the AB program allowances for dental care, prescribed drugs, and nursing home care were made within the money payment to the recipient.</p> <p>In October 1960, the State began the Federal-State program of Medical Assistance for the Aged, for persons age 65 and older who were not recipients of public assistance but who met certain criteria of medical and financial need. A comprehensive scope of services was provided, with both long-term and short-term nursing home care available. The State statute which authorized the program removed long-term nursing home care from the OAA part of the medical program because of the more advantageous Federal financial participation under the MAA program. Therefore special arrangements were made to use State funds (without Federal matching) to provide allowances for personal care items for those former recipients of OAA who were transferred to MAA in order to receive long-term nursing home care.</p> <p>These programs continued, with some modifications to adjust to the services to be provided under title XVIII, until the implementation of the title XIX program.</p>
5. Scope of Coverage	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c; B.4.b. and c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p>

### B. Medical and Remedial Care and Services

1. Inpatient Hospital Services	
a. In General Hospitals	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Blue Cross, Inc.).



**B. Medical and Remedial Care and Services (Continued)**

<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to patients age 65 or older in public institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Blue Cross, Inc.).
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to patients age 65 or older in public institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of percentage of charges. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule rate. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Blue Cross, Inc.).
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to patients age 65 or older in public institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Blue Cross, Inc.).
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to patients age 65 or older in public institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule, with higher rate for specialists. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. No limitations specified. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>b. Optometrists</b>	Provided. No limitations specified. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>c. Chiropractors</b>	Provided. No limitations specified. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>d. Other</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Blue Cross, Inc.).</p> <p>(b) Services of home health aide. Provided when furnished by home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of agency fee. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Blue Cross, Inc.).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations, but must be on order or prescription of physician. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>								
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Provided. In hospital, skilled nursing home, or patient's own home. No limitations, but must be on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of usual and customary charge. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>								
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of certified rate from Rate Setting Board. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>								
<b>11. Dental Services</b>	<p>Provided. Comprehensive services, with no limitations. Prior authorization by State agency required for orthodontia, dentures and other expensive items or services. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>								
<b>12. Physical Therapy and Related Services</b>	<table> <tr> <td data-bbox="60 1332 427 1466"> <b>a. Physical Therapy</b> </td><td data-bbox="427 1332 1509 1466"> <p>Provided. No limitations, but must be furnished on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p> </td></tr> <tr> <td data-bbox="60 1466 427 1612"> <b>b. Occupational Therapy</b> </td><td data-bbox="427 1466 1509 1612"> <p>Provided. No limitations, but must be furnished on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p> </td></tr> <tr> <td data-bbox="60 1612 427 1788"> <b>c. Speech Therapy</b> </td><td data-bbox="427 1612 1509 1788"> <p>Provided. No limitations, but must be furnished on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p> </td></tr> <tr> <td data-bbox="60 1788 427 1922"> <b>d. Audiology</b> </td><td data-bbox="427 1788 1509 1922"> <p>Provided. Limited to services provided in a medical facility. No requirements for prior authorization. Reimbursement on basis of percentage of charges. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p> </td></tr> </table>	<b>a. Physical Therapy</b>	<p>Provided. No limitations, but must be furnished on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>	<b>b. Occupational Therapy</b>	<p>Provided. No limitations, but must be furnished on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>	<b>c. Speech Therapy</b>	<p>Provided. No limitations, but must be furnished on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>	<b>d. Audiology</b>	<p>Provided. Limited to services provided in a medical facility. No requirements for prior authorization. Reimbursement on basis of percentage of charges. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>
<b>a. Physical Therapy</b>	<p>Provided. No limitations, but must be furnished on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>								
<b>b. Occupational Therapy</b>	<p>Provided. No limitations, but must be furnished on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>								
<b>c. Speech Therapy</b>	<p>Provided. No limitations, but must be furnished on recommendation of physician. No requirements for prior authorization. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>								
<b>d. Audiology</b>	<p>Provided. Limited to services provided in a medical facility. No requirements for prior authorization. Reimbursement on basis of percentage of charges. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>								



**B. Medical and Remedial Care and Services (Continued)**

<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs. On prescription of physician, dentist, or podiatrist. No limitations. No requirements for prior authorization. Reimbursement on basis of cost of drug plus dispensing fee. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. No limitations. Prior authorization by State office required for visual training, prescription sunglasses, contact lenses, plastic bifocal lenses, and trifocal lenses. Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>b. Hearing Aids</b>	Provided. No limitations, but must be prescribed by a physician. No requirements for prior authorization. Reimbursement on basis of reasonable charges. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>c. Dentures</b>	Provided. No limitations. Prior authorization by State Regional Dental Advisor is required. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Services).
<b>d. Other Prosthetic Devices</b>	Provided. Prosthetic devices to replace all or part of a body organ; braces, artificial limbs, artificial eyes; orthopedic shoes; and replacements as required by change in patient's condition. No limitations. Approval of amputee clinic required for artificial legs. Prior authorization by State office required. Reimbursement on basis of reasonable charges. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices. Must be on recommendation of physician. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule, where appropriate; otherwise, on basis of reasonable charges. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. On recommendation of a physician. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Blue Cross, Inc.).
<b>18. Emergency Hospital Services (In hospital not qualified under title XVIII or State's title XIX program)</b>	Provided, when recipient is temporarily out of State and needs emergency care. (All hospitals in Massachusetts are qualified for Title XIX payments.)
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided as required within provisions of Medical Care Plan and pertinent applicable fee schedules.

**B. Medical and Remedial Care and Services (Continued)**

<b>21. Transportation</b>  <b>a. Ambulance</b>   <b>b. Other</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Blue Cross, Inc.).</p> <p>Provided. By any appropriate means, including taxi, bus, railroad, airplane, and private vehicle. Reimbursement on basis of reasonable charges. Claims processed and paid by State Department of Public Welfare <i>or</i> (for claims which are the responsibility of the State Commission for the Blind) by fiscal agent (Massachusetts Medical Service).</p>
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**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as 90 days prior to date of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>  <b>a. Under Age 21</b>  <b>b. Age 21 to 64</b>   <b>c. Age 65 or older</b>	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p> <p>(1) Individual under age 21.</p> <p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p>(1) Individual who has attained age 65.</p>
<b>3. Coverage of the Categorically Needy</b>   <b>a. FFP Claimed in Medical and Administrative Costs</b>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(7) All individuals under age 21.</p> <p>(8) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only.)</p>



**C. Eligibility for Medical Assistance (Continued)**

	<i>Optional</i>
<b>b. FFP Claimed in Administrative Costs Only</b>	None.
<b>4. Coverage of the Medically Needy</b>	Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a., above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD, and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess, in accordance with regulations.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	<p>(1) <i>Income</i> Income may be retained for basic maintenance needs: \$2160 per year for one person, \$2832 for family of 2, \$3504 for 3, \$4176 for 4, and \$672 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$27.80 a month for personal expenses. Additional income of \$2700 a year may be applied to maintenance needs of spouse who is not living in an institution.</p> <p>(2) <i>Resources</i> May retain real property used as a home, regardless of value or equity.</p> <p>Personal effects, household furnishings, one automobile, and property (real and personal) used to produce income may be retained regardless of value.</p> <p>Other personal property (such as cash, bank deposits, securities, cash surrender value of life insurance or burial policies, boats, more than one automobile, and other assets readily convertible to cash) may be retained up to a value of \$2000 for one person, \$3000 for 2 persons, plus \$100 for each additional dependent member of the family.</p> <p>Non-home, non-income-producing real property (including vacant land) may not be retained. Applicant must agree to take immediate and continuing action to dispose of such property in order to become eligible.</p> <p>Resources in excess of the above amounts and kinds preclude eligibility until disposed of.</p>
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of husband for wife and of parents for children who are under age 21.
<b>7. Identification to Vendors of Person Eligible</b>	No medical identification card issued. Letters of eligibility sent by most Welfare Service Offices.

## D. Administration and Management

1. Medical Assistance Unit	<p>(1) <i>Department of Public Welfare:</i> The Assistant Commissioner of the Medical Division (the medical assistance unit) is responsible to the Administrator of Medical and Remedial Care. The other full-time professional staff of the unit consists of: a Director, an Assistant Director, a Chief Mental Health Coordinator, a Chief Medical Assistance Program Coordinator, and 9 Medical Assistance Program Advisors (all these positions from the field of social work or medical social work), and a Supervisor of Medical Rehabilitation (rehabilitation field). The part-time professional staff consists of: a Medical Director (M.D.); a Chief Dental Advisor and 8 Dental Advisors; a Chief Advisor in Medicine and 9 Medical Advisors; and advisors in each of the following fields — 2 in psychiatry, 2 in optometry, 2 in podiatry, and one in speech and hearing. A pharmaceutical consultant serves half time.</p> <p>(2) <i>Commission for the Blind:</i> The Director of the Medical Assistance Unit, a social worker, is directly responsible to the Commissioner of the agency. The other full-time professional staff of the unit consists of a Medical Social Consultant and 3 Medical Social Workers. The part-time professional staff consists of: 2 Medical Consultants (M.D.), a Dental Consultant, Pharmaceutical Consultant, Psychiatric Consultant, and Podiatric Consultant.</p>
2. Supervision of Statewide Operations	<p>Supervision of Statewide operations is accomplished under the Department of Public Welfare through the consultant staff and the Medical Assistance Program Advisors identified in Item D.1. above.</p> <p>Supervision of the medical aspects of Statewide operations under the Commission for the Blind is accomplished by formal contract with the State Department of Public Health. The State agency administers directly the eligibility and related aspects of the program.</p>
3. Advisory Council	<p>The State advisory body for title XIX, serving the programs under both agencies, is known as the Medical Assistance Advisory Council. It is composed of 19 members appointed by the Governor. There are no ex officio members, although the membership includes the heads of the State Department of Public Welfare, the Commission for the Blind, and the State Department of Public Health. Authority for the Council is administrative.</p>
4. Buy-In Agreement	<p>The State Department of Public Welfare and the State Commission for the Blind have each entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.</p>
5. Claims Payment Process <div data-bbox="118 1325 319 1381">a. State and Local Agencies</div> <div data-bbox="118 1503 293 1533">b. Fiscal Agents</div> <div data-bbox="118 1864 352 1921">c. Prepaid Capitation Arrangements</div>	<p>The State Department of Public Welfare processes and pays all claims from providers of all kinds of medical care and services encompassed in the plan of that agency.</p> <p>The State Commission for the Blind meets the responsibility for processing and payment of claims through contracts with two fiscal agents. See item <i>b.</i> ; below.</p> <p>The State Commission for the Blind has a contract with the Massachusetts Blue Cross, Inc., to process and pay all claims for providers of the following kinds of medical services encompassed in its title XIX plan: Inpatient hospital care in general medical institutions and in institutions for tuberculosis, skilled nursing home care in general homes and in institutions for tuberculosis (care in institutions for mental diseases for persons over age 65 is provided through the program under the Department of Public Welfare), care in Christian Science Sanatoria, services provided by home health agencies, and ambulance service.</p> <p>For all other services encompassed in the plan of the State Commission for the Blind, claims of providers are processed and paid by Massachusetts Medical Service (Blue Shield) under contract as fiscal agent.</p> <p>None.</p>



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**D. Administration and Management (Continued)**


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<b>d. Payments to Non-Medical Institutions</b>	None.
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**E. Financing**


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<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Massachusetts as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.00.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration under the plans of both agencies.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually to each agency for its specific title XIX program. Unobligated balance may not be carried over at the end of the fiscal year.
<b>4. Deficit Financing</b>	<p>If additional funds are needed before the next appropriation period, a deficiency budget may be filed, which must be approved by the House Ways and Means Committee before the Legislature votes on it.</p> <p>The State Department of Public Welfare may submit additional deficiency budgets as necessary. The Commission for the Blind may not encumber for expenses which exceed current appropriated funds.</p>

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## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Social Services

January 1, 1970

MICHIGAN

**A. General Information**

<b>1. Legal Base</b>	Sections 105-112 of the Michigan Social Welfare Act, Act 280, Public Acts of 1939, as amended.
<b>2. Beginning Dates</b>	Program went into operation on October 1, 1966. Original plan approved by the Federal agency on November 15, 1966.
<b>3. Administrative Responsibility</b>	The Michigan Department of Social Services serves as the single State agency with responsibility for administering the program on a Statewide basis, through its 83 county offices (County Department of Social Services). Pursuant to Executive Order of the Governor, a contract was entered into between the Department of Social Services and the Department of Health under which the Department of Health performs certain administrative functions related to Medicaid, including the certification of facilities and providers, medical audit and control review of medical services, and the establishment of rates for nursing home services.
<b>4. Historical Background</b>	<p>Vendor payments have been made in Michigan with Federal financial participation since 1954 for inpatient hospital services provided to OAA, AB, and APTD recipients. In 1957 the program was completely revised, effective in July. A "pooled fund" (State medical vendor account) was established as the medium for payments to vendors, the program of inpatient hospital services was expanded to include adult recipients of AFDC (children were excluded, since such care was available to them through the State's Crippled and Afflicted Children Hospitalization Program), and transportation to obtain medical care was added. In 1960, nursing care in the patient's own home was added for OAA recipients. Other medical care was recognized as an item of need in the assistance budget and an amount included in the recipient's monthly assistance grant, subject, however, to specific dollar maximums on the total payment allowable.</p> <p>In 1960, based on newly enacted legislation, a Federal-State program of Medical Assistance for the Aged (MAA) was instituted for persons age 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need. Services available under the MAA program included inpatient hospital services, post-hospital nursing home care, services of physicians and podiatrists, and in January 1966, dental care.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (See Items B.1.b. and c.)</p> <p>Services in skilled nursing homes are provided only for persons 18 years of age or older. (See Item B.4.a.)</p> <p>Certain services provided for categorically needy persons are not made available to medically needy persons. (See Items B.13., B.15)</p> <p>Certain services provided for categorically needy persons are made available on a more limited basis to medically needy persons. (See Item B.6., B.7.a. and b.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	<p>Provided. For minimum period necessary for proper care and treatment. No limitations, except no hospitalization for dental procedures unless primary admitting diagnosis is medical and not dental. No requirements for prior authorization, but recertification by physician of continuing need required after 12 days, 18 days, and each 30 days thereafter. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Michigan Hospital Service).</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older in public and private institutions. For minimum period necessary for proper care and treatment. No other limitations. No requirements for prior authorization, but joint assessment of continuing need by Department of Social Services and hospital staff required at 12 days, 18 days, and each 30 days thereafter. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Michigan Hospital Service).
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older in public and private institutions. For minimum period necessary for proper care and treatment. No other limitations. No requirements for prior authorization, but joint assessment of continuing need by a psychiatrist after 12 days, 18 days and each 30 days thereafter. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Michigan Hospital Service).
<b>2. Outpatient Hospital Services</b>	Provided. Specified services when medically necessary for the diagnosis or treatment of an illness or injury and when ordered by and under the direction of a physician. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Michigan Hospital Service).
<b>3. Other Laboratory and X-ray Services</b>	Provided. When medically necessary for diagnosis and treatment of illness or injury and when ordered by a physician. No requirements for prior authorization. Reimbursement on basis of usual and customary fee. Claims processed and paid by fiscal agent (Michigan Hospital Service).
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons 18 years of age or older. For minimum period necessary in this type of facility for proper care and treatment. No other limitations. Reimbursement on basis of negotiated rate. Claims processed and paid by State Department of Social Services.
<b>b. In Institutions For Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. For categorically needy, wherever provided, as needed (with specified exclusions), when related to diagnosed health condition or to family planning (with specified exclusions). For medically needy, unlimited when provided to hospital inpatient; when provided in office, home, or outpatient department, limited to emergency treatment; when provided in skilled nursing home, medical care facilities, and chronic care units, limited to payment of first \$50 per year plus 20% of remainder. No requirements for prior authorization. Reimbursement on basis of usual and customary charge. Claims processed and paid by fiscal agent (Michigan Medical Service).
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Same conditions as for physicians (Item B.6.). No requirements for prior authorization. Reimbursement on basis of usual and customary fee. Claims processed and paid by fiscal agent (Michigan Medical Service).
<b>b. Chiropractors</b>	Provided. Same conditions as for physicians (Item B.6.). No requirements for prior authorization. Reimbursement on basis of usual and customary fee. Claims processed and paid by fiscal agent (Michigan Medical Service).

**B. Medical and Remedial Care and Services (Continued)**

<b>c. Optometrists</b>	Not provided.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service provided by a home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of title XVIII formula. Claims processed and paid by fiscal agent (Michigan Hospital Service).</p> <p>(b) Services of home health aide. No limitations. No requirements for prior authorization. Reimbursement on basis of title XVIII formula. Claims processed and paid by fiscal agent (Michigan Hospital Service).</p> <p>(c) Medical supplies, equipment, and appliances. Provided for categorically needy only. Limited to rental of durable equipment and small list of medical accessories, on written order of physician, without prior authorization; additional items upon written approval of Medical Director of State Department. Reimbursement on basis of title XVIII formula. Claims processed and paid by fiscal agent (Michigan Hospital Service).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	<p>Not provided.</p> <p>[Family Planning Clinics included in Item B.15.]</p>
<b>11. Dental Services</b>	<p>Not provided.</p> <p>[A single-payment supplemental warrant may be issued to recipient to cover cost of certain dental services for public assistance recipients in all categories. Limited to extractions incident to use of dentures, and services recommended by physician in connection with other medical services.]</p>
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided as needed and when ordered by physician; provided by hospital for inpatients and outpatients, by home health agency for patients in own home, by medical care facility for outpatients. No requirements for prior authorization. Reimbursement on basis of title XVIII formula. Claims processed and paid by fiscal agent (Michigan Hospital Service).
<b>b. Occupational Therapy</b>	Provided as needed and when ordered by physician; provided by hospital, for inpatients and outpatients, by home health agency for patients in own home, and by private practicing therapist. No requirements for prior authorization. Reimbursement on basis of title XVIII formula. Claims processed and paid by fiscal agent (Michigan Hospital Service).
<b>c. Speech Therapy</b>	Not provided.
<b>d. Audiology</b>	Not provided.
<b>13. Prescribed Drugs</b>	<p>Provided for categorically needy persons only [except that drugs are provided to medically needy persons while hospitalized, as part of inpatient hospital services]. All legend drugs; also insulin and other non-legend drugs usually prescribed for specifically diagnosed illness and specified related medical accessories when prescribed. No limitations. No requirements for prior authorization. Reimbursement on basis of acquisition cost plus a \$2.00 professional fee, but not to exceed usual and customary charge to general public. Claims processed and paid by fiscal agent (Michigan Medical Service).</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>  <b>a. Eyeglasses</b>          <b>b. Hearing Aids</b>          <b>c. Dentures</b>          <b>d. Other Prosthetic Devices</b>	<p>Not provided.</p> <p>[A single-payment supplemental warrant may be issued to recipient to cover purchase or repair of eyeglasses for public assistance recipients in all categories.]</p> <p>Not provided.</p> <p>[A single-payment supplemental warrant may be issued to recipient to cover purchase or repair of hearing aids for public assistance recipients in all categories. Cost of replacement of hearing aid batteries may be included on a continuing basis in the assistance budget.]</p> <p>Not provided.</p> <p>[A single-payment supplemental warrant may be issued to recipient to cover the cost of dentures for public assistance recipients in all categories.]</p> <p>Not provided.</p> <p>[A single-payment supplemental warrant may be issued to recipient to cover cost of corrective appliances for non-hospitalized public assistance recipients in all categories. Cost of such appliances for hospitalized recipients is included in Medical Assistance vendor payment to hospital.]</p>
<b>15. Family Planning Services</b>	<p>Provided for categorically needy persons only; including drugs, supplies, and devices, as provided by a qualified family planning clinic, by M.D. or D.O., and by pharmacy. No requirements for prior authorization. Reimbursement on basis of usual and customary fee. Claims processed and paid by fiscal agent (Michigan Medical Service).</p>
<b>16. Services of Christian Science Nurses</b>	<p>Not provided.</p>
<b>17. Care and Services in Christian Science Sanatoria</b>	<p>Not provided.</p>
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	<p>Provided. Limited to duration of emergency or until transfer to approved facility is feasible. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Michigan Hospital Service).</p>
<b>19. Personal Care Services In Patient's Home</b>	<p>Not provided.</p>
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	<p>Not provided.</p>
<b>21. Transportation</b>  <b>a. Ambulance</b>          <b>b. Other</b>	<p>Provided. Limited to trips to and from hospital for inpatient services or for emergency treatment. No requirements for prior authorization, but must be upon order of physician. Reimbursement on basis of title XVIII formula. Claims processed and paid by fiscal agent (Michigan Hospital Service).</p> <p>Not provided.</p> <p>[A medical transportation allowance may be included in the assistance budget for visits to physician's office or a clinic, when need is verified by client's physician.]</p>

### C. Eligibility for Medical Assistance

<b>1. Date of Entitlement</b>	Individuals meeting conditions of eligibility are entitled to medical assistance under the program for services received on or after the first day of the month of application.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	(1) Individual under age 21.
<b>b. Age 21 to 64</b>	<p>(1) Parent or caretaker relative (as specified in AFDC plan) with whom a child deprived of parental support or care is living.  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(6) All individuals under 21.</p>
<b>b. FFP Claimed in Administrative Costs Only</b>	None.
<b>4. Coverage of the Medically Needy</b>	Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a.(1) through (6), above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD, and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.



### C. Eligibility for Medical Assistance (Continued)

<p><b>b. For Medically Needy Persons</b></p>	<p>(1) <i>Income</i>  Net annual income (defined as income less allowable deductions as in the related categorical assistance plan and cost of medical care not encompassed within the MA plan) which may be retained for basic maintenance needs: \$1900 for one person, \$2700 for family of 2, \$3120 for 3, \$3540 for 4, and \$420 for each additional member of the family household.</p> <p><i>Persons in chronic (long-term) care in a medical facility</i> may retain the following income:</p> <p>(a) Income according to above maintenance scale if in the medical facility for less than one month;</p> <p>(b) Income according to above maintenance scale (regardless of length of stay in the medical facility) if maintaining a home in which his spouse or dependent children (blind, disabled, or minor) are living;</p> <p>(c) \$20 a month, if in the medical institution for more than one month and is not maintaining a home.</p> <p>(2) <i>Resources</i>  Homestead <i>or</i> a land contract or mortgage arising from the sale of the homestead is exempt.</p> <p>The following personal property is exempt, regardless of value: Clothing, household effects, and tangible personal property used in earning an income. Up to \$1000 cash surrender value of family's life insurance is exempt.</p> <p>Other real and personal property may be retained up to \$1500 for one person, \$2000 for two persons, plus \$200 for each additional member of the family group.</p> <p>Resources in excess of these protected property levels renders the applicant or recipient ineligible.</p>
<p><b>6. Financial Responsibility of Relatives</b></p>	<p>The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse, and of parents for children under age 21.</p>
<p><b>7. Identification to Vendors of Persons Eligible</b></p>	<p>A Medical Assistance Identification Card is issued to each one-person or multiple-person case certified as eligible, stating whether authorized for Group 1 (categorically needy) or Group 2 (medically needy) services. Name of each individual covered, period of eligibility, amount, if any, to be paid by medically needy for institutional care and to reduce income to protected level, appear on card.</p>

### D. Administration and Management

<p><b>1. Medical Assistance Unit</b></p>	<p>The Office of Medical Services (medical assistance unit) is located organizationally directly under the Office of the Director of the State Department of Social Services. Full-time professional staff serving under the Director (M.D.) of the Office of Medical Services consists of an Assistant Medical Director (M.D.), Pharmacist, 5 Physician Consultants, 2 Nurse Consultants (RN), a Public Welfare Administrator (MSW), and 5 Medical Social Workers. The services of 3 additional Physician Consultants are also available on a part-time basis.</p>
<p><b>2. Supervision of Statewide Operations</b></p>	<p>Supervision of Statewide operations is accomplished through the staff of consultants listed above (Item D.1.) and through the general field staff of the State agency. In one metropolitan county (Wayne), there is a separate medical assistance unit; and each county office has a patient evaluation team which serves under the county director and is typically composed of a physician (M.D. or D.O.), a registered nurse, and a social worker.</p>
<p><b>3. Advisory Council</b></p>	<p>The State advisory body for title XIX is known as the Medical Care Advisory Commission. It is composed of 18 members, consisting of the Director of the State Department of Social Services, the Director and Assistant Director of the Office of Medical Services, and 15 members appointed by the Governor. Authority for the Commission is administrative.</p>
<p><b>4. Buy-In Agreement</b></p>	<p>State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients who are eligible for benefits under title XVIII of the Social Security Act.</p>

**D. Administration and Management (Continued)**

<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	Claims for services provided by skilled nursing homes are processed and paid by the State Department of Social Services. All other medical vendor claims are handled by fiscal agents.
<b>b. Fiscal Agents</b>	State agency has two currently active fiscal agent contracts. The contract with Michigan Hospital Service (Blue Cross) covers the processing and payment of claims submitted by general hospitals, institutions for tuberculosis and mental diseases, and home health agencies. The second contract, with Michigan Medical Service (Blue Shield), covers claims received from all other medical vendors and suppliers (except skilled nursing homes, as noted in subparagraph a., above).
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Michigan as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from funds appropriated annually by the State legislature. Use of funds is restricted by the practice of appropriating on a line item basis according to type of medical care. Unexpended balance may not be carried over but reverts to the General Fund at the end of each fiscal year.
<b>4. Deficit Financing</b>	State constitution prohibits deficit spending. Appropriation bills customarily contain a provision requiring that payments be reduced on a pro rata basis in the event the amount appropriated is "less than the amount called for or required to be distributed".



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

MINNESOTA

**A. General Information**

<b>1. Legal Base</b>	Minnesota Statutes, Chapter 256B. (Specific legislation authorizing a medical assistance program contained in Chapter 755, Laws of 1965).
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1966. Original plan approved by the Federal agency on March 31, 1966.
<b>3. Administrative Responsibility</b>	The Department of Public Welfare serves as the single State agency with responsibility for supervising the administration of the program on a Statewide basis through the county boards of public welfare in the 87 counties.
<b>4. Historical Background</b>	<p>Vendor payments from State funds, with Federal financial participation, for costs of medical care provided to recipients of public assistance began in October 1950. The State was one of the first to use the option for such Federal matching authorized by a 1950 amendment to the Social Security Act. In 1954 the State had a system of "county pooled funds" into which capitation payments were made as a method of meeting the seasonal fluctuations in the use and costs of medical care. Since the APTD program began in 1954, recipients of aid under that category were also provided coverage.</p> <p>In 1957 a completely revised plan for the medical services was submitted and approved. By 1961, a full scope of services was being provided to recipients in all four categories, although recipients of APTD were subject to a statutory maximum on the costs of care which was not removed until 1965. Nursing home care was paid for through a combination of money and vendor payments, with the first \$60 being considered a "room and board component" and included in the money payment to the recipient. These services were also available to persons who met all the eligibility requirements for a public assistance category except that they had been able to meet their maintenance needs and applied for aid because of the costs of medical care.</p> <p>In 1963 legislation was enacted to permit implementation of the Federal-State program of Medical Assistance for the Aged (MAA) for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. Services began under this program July 1, 1964. A broad scope of services was provided, with administrative controls on duration or rates. To be eligible, an applicant or his spouse must have paid or obligated to pay \$200 for medical care in the 12 months preceding the application. However, the requirement could be met by expenditures for health insurance premiums or by payments made in behalf of the applicant by relatives, welfare agencies, or charitable organizations; and the deductible was waived if the gross annual income of the applicant was less than the amount set by the State as the eligibility level for MAA. The program continued until the end of 1965 and the beginning of medical assistance under the title XIX program.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.; B.4.b. and c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p>

**B. Medical and Remedial Care and Services**

<p><b>1. Inpatient Hospital Services</b></p> <p><b>a. In General Hospitals</b></p> <p><b>b. In Institutions for Tuberculosis</b></p> <p><b>c. In Institutions for Mental Diseases</b></p>	<p>Provided. No limitations. No requirements for prior authorization, but hospital's notification to county office that patient's stay will continue beyond a 30-day period is subject to review and approval by the hospital's utilization review committee or (in the absence of such hospital committee) by the county medical advisory committee. Reimbursement on basis of reasonable cost. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p> <p>Provided. Limited to patients age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p> <p>Provided. Limited to patients age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>
<p><b>2. Outpatient Hospital Services</b></p>	<p>Provided. No limitations. County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/1/70). Reimbursement on basis of schedule of allowances established by individual county, but not to exceed State maximum which is established as reasonable charges. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>
<p><b>3. Other Laboratory and X-ray Services</b></p>	<p>Provided. No limitations. County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/1/70). Reimbursement on basis of schedule of allowances established by individual county but not to exceed State maximum which is established as reasonable charges. Claims in St. Louis county processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>
<p><b>4. Skilled Nursing Home Services</b></p> <p><b>a. General</b></p>	<p>Provided. For persons of all ages. No limitations. No requirements for prior authorization, but county agency's approval of a plan for nursing home care is usually obtained prior to placement of patient coming from non-institutional setting. County agency's review of need for skilled nursing home care required in order to determine and periodically reaffirm the classification of care and rate of payment. County welfare board of each county required to establish maximum rates of payment for facilities within the county (either a per diem rate or maximum fees for varying levels of care), subject to review and approval by State agency. Payment may not be made at rates in excess of these maxima, but county may negotiate with individual homes for payment of a lower fee. Reimbursement to State geriatric facilities on basis of rates determined by Commissioner of Public Welfare; of private facilities on basis of rates set by county in which facility is located. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>b. In Institutions for Tuberculosis</b>	<p>Provided. Limited to patients age 65 or older in public or private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>
<b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to patients age 65 or older in public or private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. No limitations except that patient must remain under the care of physician of first choice unless his request for change, based on a valid reason, is approved by county office. Payment for physicians' services during a given illness limited to one physician, with additional payment for consultation by one other physician if patient refuses to accept diagnosis or recommended treatment. County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/1/70). Each county required to establish, by agreement with providers residing in the county, a schedule of allowances which may be different from but not in excess of the State agency maximum, which is established as the practitioner's usual and customary charges. Reimbursement on basis of county schedule of allowances. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>          <b>b. Optometrists</b>	<p>Provided. No limitations. County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/1/70). Each county required to establish, by agreement with providers residing in the county, a schedule of allowances which may be different from but not in excess of the State agency's maximum fee schedule. Reimbursement on basis of county schedule of allowances. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p> <p>Provided. No limitations. County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/1/70). Each county required to establish, by agreement with providers residing in the county, a schedule of allowances which may be different from but not in excess of State agency's maximum fee schedule. Reimbursement on basis of county schedule of allowances. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>c. Chiropractors</b>	Provided. No limitations. County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/1/70). Each county required to establish, by agreement with providers residing in the county, a schedule of allowances which may be different from but not in excess of the State agency's maximum fee schedule. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. As provided by a certified home health agency, or, in absence of such agency, by a visiting nurse association or by a private-practicing RN or LPN. No limitations so long as provided under general direction of attending physician. No requirements for prior authorization. Each county required to establish, by agreement with providers residing in the county, a schedule of allowances which may be different from but not in excess of the State agency maximum which is established for home health agencies as reasonable cost and for visiting nurse associations and private practicing RN's and LPN's as fees set by State Nurses Association and State Licensed Practical Nurses Association. Reimbursement on basis of county schedule of allowances. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p> <p>(b) Services of home health aide. As provided by a certified home health agency. No limitations so long as provided under general direction of attending physician. No requirements for prior authorization. Each county required to establish, by agreement with providers residing in the county, a schedule of allowances which may be different from but not in excess of the State agency maximum which is established for home health agencies as reasonable cost. Reimbursement on basis of county schedule of allowances. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/1/70). Reimbursement on basis of schedule of allowances established by county agency but not in excess of State agency established pricing schedule. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Provided. In home (if services not available through local home health agency), hospital, and skilled nursing home. No limitations so long as provided under general direction of attending physician. No requirements for prior authorization. Each county required to establish, by agreement with providers residing in the county, a schedule of allowances which may be different from but not in excess of the State agency maximum which, for RN's and LPN's is established as fees set by State Nurses Association and State Licensed Practical Nurses Association. Reimbursement on basis of county schedule of allowances. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.
<b>10. Clinic Services (Other than Hospital)</b>	Provided. No limitations. County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/1/70). Reimbursement on basis of schedule of allowances established by individual county but not to exceed State maximum which is established as reasonable charges. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.



**B. Medical and Remedial Care and Services (Continued)**

11. Dental Services	<p>Provided. No limitations except that orthodontia is provided only for cases approved by the State Orthodontic Review Committee. State agency's Dental Fee Schedule specifies certain procedures and materials for which county agency must give individual consideration (e.g., periodontia treatment, space maintainers, and surgery) and/or prior authorization (e.g., dentures, bridge work, gold fillings). Additional requirements for prior authorization may be established by individual county agencies, most of which have done so for all dental care except emergency and routine work below a specified dollar amount. Each county required to negotiate with county dental advisory committee for a county dental fee schedule which may be different from but not higher than the State agency's fee schedule of maximum allowances. Reimbursement on basis of county fee schedule. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>								
12. Physical Therapy and Related Services	<table border="1"> <tr> <td data-bbox="172 667 384 693">a. Physical Therapy</td><td data-bbox="491 667 1528 873"> <p>Provided. As furnished by a certified home health agency, private-practicing licensed therapist, or other qualified provider. No limitations, but must be recommended by physician. County agency may establish prior authorization requirements (none in effect as of 1/1/70). Reimbursement on basis of county schedule of allowances (variable according to provider utilized) but not to exceed State maximum which is established as reasonable charges. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p> </td></tr> <tr> <td data-bbox="172 905 344 961">b. Occupational Therapy</td><td data-bbox="491 905 1528 1110"> <p>Provided. 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County agency may establish prior authorization requirements (none in effect as of 1/1/70). Reimbursement on basis of county schedule of allowances (variable according to provider utilized) but not to exceed State maximum which is established as reasonable charges. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p> </td></tr> <tr> <td data-bbox="172 1379 316 1404">d. Audiology</td><td data-bbox="491 1379 1528 1598"> <p>Provided. As furnished by a private-practicing audiologist certified by the American Speech and Hearing Association or other qualified provider. No limitations, but must be recommended by physician. County agency may establish prior authorization requirements (none in effect as of 1/1/70). Reimbursement on basis of county schedule of allowances (variable according to provider utilized) but not to exceed State maximum which is established as reasonable charges. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p> </td></tr> </table>	a. Physical Therapy	<p>Provided. As furnished by a certified home health agency, private-practicing licensed therapist, or other qualified provider. No limitations, but must be recommended by physician. County agency may establish prior authorization requirements (none in effect as of 1/1/70). Reimbursement on basis of county schedule of allowances (variable according to provider utilized) but not to exceed State maximum which is established as reasonable charges. 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13. Prescribed Drugs	<p>Provided. Legend and non-legend drugs. Limit of 30-day supply per prescription except that 100-day supply allowed for chronic illness. Refills allowed up to number indicated on original prescription. No other limitations. Payment to physician for dispensed drugs allowed in areas where registered pharmacist is not available. County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/1/70). Reimbursement on basis of State agency's Prescription Pricing Schedule or pharmacist's usual charge to general public, whichever is lower. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>								





**B. Medical and Remedial Care and Services (Continued)**

<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	<p>Provided. Diagnostic and screening services available per agreement with Crippled Children's Services. Specialized para-medical services provided in all categories per physician request. Reimbursement on basis of reasonable charges. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, by County Welfare Board.</p>
<b>21. Transportation</b>  <b>a. Ambulance</b>          <b>b. Other</b>	<p>Provided. As furnished by a recognized ambulance service when needed to obtain medical care. No limitations. Reimbursement on basis of schedule of allowances established by individual county but not in excess of State maximum, which is established as reasonable charges. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p> <p>Provided. Transportation by airplane, train, bus, Handicab, or taxicab. Including cost of meals and lodging enroute and while receiving medical care away from home, if required. No limitations. County agency may establish prior authorization requirements subject to State agency approval (none in effect as of 1/1/70). Reimbursement on basis of schedule of allowances established by individual county but not in excess of State maximum, which is established as reasonable charges. Claims in St. Louis County processed and paid by fiscal agent (Blue Shield of Minnesota and Minnesota Hospital Service Association); in all other counties, processed and paid by County Welfare Board.</p>

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	<p>Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the third month prior to the month of application, provided all conditions of eligibility were met in the month in which services were rendered.</p>
<b>2. Conditions of Eligibility (By Age Groups)</b>  <b>a. Under Age 21</b>  <b>b. Age 21 to 64</b>          <b>c. Age 65 or older</b>	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a:</p> <p>(1) Individual under age 21.</p> <p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.  (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(1) Individual who has attained age 65.</p>
<b>3. Coverage of the Categorically Needy</b>          <b>a. FFP Claimed in Medical and Administrative Costs</b>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p>

**C. Eligibility for Medical Assistance (Continued)**

<p>a. FFP Claimed in Medical and Administrative Costs—Continued</p>	<p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) All individuals under age 21.</p>
<p>b. FFP Claimed in Administrative Costs Only</p>	<p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
<p>4. Coverage of the Medically Needy</p>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Items C.3.a., above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess, in accordance with the regulations.</p>
<p>5. Financial Criteria</p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p>
<p>a. For Categorically Needy Persons</p>	<p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>
<p>b. For Medically Needy Persons</p>	<p>(1) <i>Income</i> Annual income which may be retained for basic maintenance needs: \$1740 for one person, \$2424 for family of 2, \$3000 for 3, \$3516 for 4, and \$516 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$11 a month for personal expenses. Additional income may be applied to maintenance needs of dependents up to \$1740 per year for one dependent, \$2424 for 2 dependents, and higher amounts for additional dependents (according to progression stated in preceding paragraph).</p> <p>(2) <i>Resources</i> Real property, including home, may be retained up to an equity of \$15,000.</p> <p>The following personal property is exempt regardless of value: Household goods and furniture in use; wearing apparel; trailer home; and a burial plot for each person.</p> <p>Prepaid burial contracts are exempt up to value of \$600 for one person, \$1000 for two persons, plus \$150 for each additional person.</p> <p>Life insurance policy on each insured member of the family unit is exempt up to a cash surrender value of \$1000. (Excess value may not be substituted for lack of other allowable liquid assets; holding by any family member of a policy exceeding the \$1000 limit precludes eligibility.)</p> <p>Other personal resources such as cash, savings accounts, stocks, bonds, and an automobile, may be retained up to a value of \$750 for one person, \$1000 for two, plus \$150 for each additional member of the family unit.</p> <p>The holding of resources in excess of these limitations precludes eligibility.</p>



**C. Eligibility for Medical Assistance (Continued)**

<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21.
<b>7. Identification to Vendors of Persons Eligible</b>	A Medical Assistance Identification Card is issued by the county agency to all families or persons certified as eligible. County may use the standard card available from the State agency or may obtain approval for use of a substitute card. Face of the State agency standardized card shows county of issuance, case number, program code, and name of the person to whom issued. At the option of each county, a single card may be issued to each family listing the names of all persons eligible in the case, or a separate card may be issued in the name of each eligible family member. County agency determines frequency of issuance, which may vary for different categories or different types of cases, e.g., a card for continuing money payment cases might be valid for a year while certain "spend-down cases" might be valid for only two months. Expiration date of card's validity appears on the face of each card.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Supervisor of the Medical Assistance Unit (a social worker, MSW) is directly responsible to the Director, Division of Public Assistance, and is assisted by a physician (M.D.) Director of Medical Assistance who devotes part time to this function. The full-time staff consists of a Pharmacy Consultant (R.Ph.), a Medical Care Consultant-MA Unit (MSW, MPH), and a Medical Social Work Consultant (MSW). The Unit has also the part-time services of a Physician Consultant-MA Unit (M.D.) and a Dental Consultant (D.D.S.)
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the regular field staff of the Division assigned to the 17 district offices. In addition, there is a medical assistance unit in the welfare department in each of the 2 large metropolitan counties. In St. Louis County, the full-time director is from the field of Hospital Administration and has the part-time services of a physician on his staff; in Hennepin County the director is a Medical Social Worker with 2 part-time physicians and a part-time pharmacy consultant.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Title XIX Medical Assistance Advisory Committee. It is composed of 21 members appointed by the Commissioner of Public Welfare. There are 5 ex officio members (Commissioner of Public Welfare, Director of Division of Public Assistance, Program Administrator, Pharmacy Consultant, and Dental Consultant). Authority for the Committee is administrative.
<b>4. Buy-in Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
a. State and Local Agencies	State agency is not directly involved in the processing and payment of claims. All such procedures are handled by the county agencies except in the case of St. Louis County, which has entered into a fiscal agent contract with Minnesota Blue Cross/Blue Shield.
b. Fiscal Agents	St. Louis County has entered into a joint fiscal agent contract with Minnesota Hospital Service Association and Blue Shield of Minnesota (Blue Cross/Blue Shield) for the processing and payment of all claims for services rendered by providers of medical services residing in the county or furnishing services to recipients for whom the county agency is responsible.
c. Prepaid Capitation Arrangements	None.
d. Payments to Non-Medical Institutions	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Minnesota as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 56.95.
<b>2. State/Local Participation</b>	State funds are used to pay the non-Federal share of the State office administrative costs and county funds to meet local office administrative costs. State and county funds are used to meet medical assistance costs on a 50-50 basis. State equalization aid is limited to a maximum of 14 specific distressed counties based on a formula which includes four factors: recipient rate, per capita income, per capita taxable value, and per capita expenditure for welfare.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially from the State's general funds. Unobligated balance may be carried over within the biennium but reverts to the General Fund at the end of the biennium.
<b>4. Deficit Financing</b>	If additional funds are needed before the next appropriation period, the emergency may be met by transfer of excess funds from other federally aided welfare accounts, if an excess is available.



# MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Mississippi Medicaid Commission

January 1, 1970

MISSISSIPPI

## A. General Information

<b>1. Legal Base</b>	H.B. No. 2 (1969 Extraordinary Session, Mississippi Legislature)
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1970. Original plan approved by the Federal agency on December 31, 1969.
<b>3. Administrative Responsibility</b>	The Mississippi Medicaid Commission serves as the single State agency with responsibility for administering the program on a Statewide basis. The State Department of Public Welfare has responsibility for determination of eligibility for medical assistance.
<b>4. Historical Background</b>	Provisions for the Department of Public Welfare to make vendor payments for hospital care for OAA recipients began in April 1961 under a temporary plan. It was given a statutory base in 1962 by legislation which extended it to AB, APTD, and AFDC. However, because of limited funds, payments for hospital care for AB recipients was not effective until February 1964 and for APTD recipients not until February 1967. It was not implemented for AFDC prior to January 1970. Nursing home care, which had previously been paid for through the money payment to the recipient, was added to the vendor payment provisions in April 1967 for recipients of OAA, AB, and APTD. Also in 1967, certain modifications were made to correlate the services provided for recipients aged 65 and over who were eligible for and enrolled in the Medicare program (Title XVIII of the Social Security Act). The State had legal authority since 1964 for the program of Medical Assistance for the Aged ( a Federal-State program for medically indigent persons aged 65 and over); but the appropriations available were never sufficient to put the program into operation, and with the enactment of Title XVIII with services for the same age group, the pressure for the MAA program ceased.
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis are provided only for patients who are 65 years of age or older. (Items B.1.b.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B.7.a.; B.8.a., b., and c.; B.10.; B.12.a., b., and c.; B.14.d.; B.21.a.)</p> <p>Certain services covered as benefits under Medicare are made available on a more liberal basis for persons covered by the State's buy-in agreement (Items B.2., B.6.)</p>

## B. Medical and Remedial Care and Services

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. Limited to 40 days per fiscal year. Prior authorization by State Medicaid Commission or its fiscal agent required for extension beyond first 20 days. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).

**B. Medical and Remedial Care and Services (Continued)**

<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>2. Outpatient Hospital Services</b>	Provided. Unlimited services for persons age 65 or older covered by State's buy-in agreement; for others, limited to 30 outpatient visits per fiscal year. No requirements for prior authorization. Reimbursement on basis of 75% of charges; payment for laboratory and X-ray services not to exceed payments made to independent laboratories and providers of X-ray services. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitation on services provided by an independent laboratory qualified to be certified under title XVIII. Payment for laboratory services provided in physician's office limited to urinalysis, hematocrit, hemoglobin, WBC, CBC, and blood sugar. No requirements for prior authorization. Reimbursement on basis of fixed fee schedule; payment not to exceed 75th percentile of customary charges or of fees under Part B, title XVIII, whichever is less. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No limitations. Prior authorization from State agency required after first 90 days in a fiscal year. Reimbursement based on following computation: From maximum allowable charge (billing rate set for individual nursing home based on annual cost report) are subtracted any resources available to recipient and any supplementation payments made to the home by a relative or other third party; vendor payment of all or part of the remainder is made in an amount up to but not in excess of the Statewide maximum payment set by the Medicaid Commission.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Provided. The Mississippi Medicaid Commission has contracted with the State Board of Health to perform a battery of screening and diagnostic tests on eligible recipients under 21 years of age. Abnormalities not covered by one of the State Board of Health services are referred to private physicians, and services are then provided under and within the scope of the State's title XIX program. Reimbursement is made to the State Board of Health on the basis of a negotiated fee (\$8 per child) related to provider's cost for performing the services. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>6. Physicians' Services (M.D. and D.O.)</b>	Unlimited services for persons age 65 or older covered by State's buy-in agreement. For others, visits to hospital inpatient limited to one per day; visits to patient in skilled nursing home limited to 36 per fiscal year; unlimited visits elsewhere; laboratory services provided in physician's office limited to 6 routine procedures (hematocrit, hemoglobin, blood sugar, urinalysis, WBC, and CBC). No requirements for prior authorization. Reimbursement on basis of fixed fee schedule (developed on basis of California 1964 Relative Value Index, with conversion factor of 4). Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	<p>Provided. Limited to persons age 65 or older covered by State's buy-in agreement, and to such services available as benefits under Part B of Medicare. No requirements for prior authorization. Reimbursement on basis of usual and customary charges.</p> <p>Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).</p>
<b>b. Optometrists</b>	Not provided.



<b>B. Medical and Remedial Care and Services (Continued)</b>	
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided, as furnished by a certified home health agency. Limited to persons age 65 or older covered by State's buy-in agreement. 100 visits per year (within combined total of 100 home health agency visits per year). No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).</p> <p>(b) Services of home health aide. Provided, as furnished by a certified home health agency. Limited to persons age 65 or older covered by State's buy-in agreement. 100 visits per year (within combined total of 100 home health agency visits per year). No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. Limited to persons age 65 or older covered by State's buy-in agreement, and to such items as are available as benefits under Part B of Medicare. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>11. Dental Services</b>	Not provided.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement; and limited to services available as benefits under Part B of Title XVIII (Medicare). No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>b. Occupational Therapy</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement; and limited to services provided by a qualified home health agency, within maximum limit of 100 visits per year for all home health agency visits. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>c. Speech Therapy</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement; and limited to services provided by a qualified home health agency, within maximum limit of 100 visits per year for all home health agency visits. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>d. Audiology</b>	Not provided.
<b>13. Prescribed Drugs</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Not provided.
b. Hearing Aids	Not provided.
c. Dentures	Not provided.
d. Other Prosthetic Devices	Provided. Limited to persons age 65 or older covered by State's buy-in agreement. Devices to replace all or part of an internal organ, and other devices available as benefits under Part B of title XVIII (Medicare). No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims for Medicare deductible and coinsurance processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>15. Family Planning Services</b>	Not provided.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. Limited to 10 days per fiscal year. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Limited to 20 days per fiscal year. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost based on cost report or 85% of charges. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
a. Ambulance	Provided. Limited to persons age 65 or older covered by State's buy-in agreement, and subject to same limiting conditions applicable to availability of the service as a Medicare benefit. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Mississippi Hospital and Medical Service).
b. Other	Not provided.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as ten days prior to the date of application, provided all conditions of eligibility were met in the month in which services were rendered.
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**C. Eligibility for Medical Assistance (Continued)**

<b>2. Conditions of Eligibility (By Age Groups)</b>	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p>
<b>a. Under Age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Child in foster home or private institution for whom a public agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</p> <p>(4) Person who is blind (State definition); and who, if under age 18 and capable of doing so, is attending public school or school for blind.</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p>
<b>b. Age 21 to 64</b>	<p>(1) Person who is blind (State definition).</p> <p>(2) Person who is permanently and totally disabled (State definition).</p> <p>[Note: Parent or caretaker relative (with whom a child deprived of parental support or care is living) is not included in State's AFDC plan as a "recipient" and, similarly, is not covered by title XIX plan.]</p>
<b>c. Age 65 or older</b>	<p>(1) Individual who has attained age 65.</p>
<b>3. Coverage of the Categorically Needy</b>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p>
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(1) All children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part.</p> <p>(2) Persons in a medical facility (including patients age 65 or older in an institution for tuberculosis) who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(3) AFDC children who would be eligible in the public assistance category except that their budget deficit is less than the State's minimum money payment, or less than the payment under the percentage reduction, when included with children in the group 16 to 21 years of age.</p>
<b>b. FFP Claimed in Administrative Costs Only</b>	<p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
<b>4. Coverage of the Medically Needy</b>	<p>Not included.</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	Not applicable.
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.
<b>7. Identification to Vendors of Persons Eligible</b>	In January, 1970, at the time program began, an identification card was issued to each person certified as eligible for medical assistance. [State plans to issue cards on a regular monthly basis which will be valid for month of issuance only.]

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Mississippi Medicaid Commission is a separate agency which is, itself, the medical assistance unit. The director is a physician (M.D., M.P.H.) who has a staff of 8 full-time positions: Assistant Director, Administrative Assistant, Reimbursement Section Manager (C.P.A.), Fiscal Auditor, Claims Auditor, Staff Pharmacist, Medical Social Worker, and Program Analyst. In addition there is a Dental Consultant and a Staff Writer who serve part time.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operation of the medical aspects is accomplished through Director, Assistant Director, medical social worker, staff pharmacist, nurse, and dental consultant of the Medicaid Commission.  The State Department of Public Welfare exercises Statewide supervision over the determination of eligibility through its regular field staff.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Advisory Council and Technical Advisory Committees. The Council is composed of 30 members. Professional Associations name the Technical Advisory Committees; chairmen of these committees plus the ex officio members form the Advisory Council. There are 4 ex officio members (Executive Officer, State Board of Health; Commissioner, Department of Welfare; Administrative Director, Crippled Children's Service; Director, Division of Vocational Rehabilitation). Authority for the Council is statutory.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	State agency does not directly engage in the day-to-day processing and payment of vendor claims but fulfills its administrative responsibility for such operations through the medium of a fiscal agent.
<b>b. Fiscal Agents</b>	State has entered into a contract with Mississippi Hospital and Medical Service (Blue Cross-Blue Shield) for processing, auditing, and payment of all claims for medical care and services provided under the program.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.



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**E. Financing**

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<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Mississippi as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 83.00.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually and designated for title XIX only. Unobligated balance may not be carried over at the end of the fiscal year, but reverts to the General Fund at the end of the fiscal year.
<b>4. Deficit Financing</b>	If additional funds are needed before the next appropriation period, payment for services would be prorated until the new fiscal year.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Health and  
Welfare (Division of Welfare)

January 1, 1970

MISSOURI

### A. General Information

1. Legal Base	Chapters 208 and 209, Revised Statutes of Missouri 1959, as amended.
2. Beginning Dates	Program went into operation on October 13, 1967. Original plan approved by the Federal agency on October 23, 1967.
3. Administrative Responsibility	The Missouri Division of Welfare (of the State Department of Public Health and Welfare) serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of 115 county welfare offices.
4. Historical Background	<p>Vendor payments for the costs of medical care were first made as part of the public assistance program with Federal financial participation in October 1959 for recipients of OAA, APTD, and AFDC. Inpatient hospital care for "medical emergencies or acute serious illness" was the only service provided until nursing home care for OAA was added in May 1961. For the AB program, inpatient hospital care was provided through a special allowance for hospital-surgical insurance premiums available to recipients of AB along with persons receiving the State pension for the blind. Other medical services recognized by the State in its standard of assistance could be provided only within the money payment to the recipient for subsistence needs, subject to the monthly maximum on such payments.</p> <p>In 1963, the scope of services was increased for OAA and APTD by the addition of certain specified dental care (except for dentures) and certain specified prescribed drugs essential in the treatment of a specific list of chronic diseases. At the same time the definition of hospital care was liberalized by removing the "medical emergency" phrase and replacing it with the phrase "serious illness or injury for which outpatient care will not suffice." "Elective surgery, diagnostic studies, and chronic conditions" were still excluded. In 1965, services for these two categories of recipients were further broadened by adding "dentures" to the scope of dental services and by liberalizing prescribed drugs.</p> <p>Between 1961 and 1965 the General Assembly considered several bills to implement the Federal-State program of Medical Assistance for the Aged, for persons age 65 and older who were not recipients of public assistance but met certain criteria of financial and medical need. Because of the problems, the estimated costs, and the minimal appropriation offered, the bills were not enacted.</p> <p>With the beginning of Medicare under title XVIII, the State modified the content of its vendor payment provisions for persons age 65 and older to coordinate with the provisions of title XVIII. For persons under the age of 65, the scope of services paid for by vendor payments or allowed for within the subsistence budget remained essentially unchanged until the implementation of title XIX.</p>
5. Scope of Coverage	Program provides coverage for categorically needy persons only. (See Item C.3.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B.7.a.; B.8.; B.10.; B.12.a., b., and c.; B.14.d.)</p>



**B. Medical and Remedial Care and Services**

<p><b>1. Inpatient Hospital Services</b></p> <p><b>a. In General Hospitals</b></p> <p><b>b. In Institutions for Tuberculosis</b></p> <p><b>c. In Institutions for Mental Diseases</b></p>	<p>Provided. In Medicare-certified hospitals which have a signed participation agreement with State agency. Including private room when medically necessary or when semi-private accommodations are unavailable. No limitations. No requirements for prior authorization for initial admission, but hospital must (except when stay is covered as a Medicare benefit) present medical justification and request prior authorization for stay extending beyond 21 days per admission. Reimbursement on basis of reasonable cost (as paid by Medicare). Claims processed and paid by State Division of Welfare.</p> <p>Provided. Limited to patients age 65 or older in State institutions which have entered into a participation agreement with State agency. No other limitations. No requirement for prior authorization on the initial admission, but the hospital must request prior authorization for any stay in excess of 21 days per admission. Reimbursement on basis of reasonable cost. Claims processed and paid by State Division of Welfare.</p> <p>Provided. Limited to patients age 65 or older in State institutions which have entered into a participation agreement with State agency. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Division of Welfare.</p>
<p><b>2. Outpatient Hospital Services</b></p>	<p>Provided. By Medicare-certified hospitals which have a signed participation agreement with the State agency. Dispensed drugs limited to injectable medications which cannot be self-administered, unless hospital having a licensed pharmacy has entered into an agreement to participate in the drug vendor program. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charge as established by State agency, except that (1) reimbursement for Medicare-covered services is made by payment of dollar amount of outstanding deductible and/or coinsurance as computed by Medicare intermediary, and (2) reimbursement is based on a negotiated rate for services provided in the out-patient department or emergency room of a government-owned hospital or of a licensed hospital which is associated with a medical school or has an approved fellowship, intern, and/or residency program. Claims processed and paid by State Division of Welfare.</p>
<p><b>3. Other Laboratory and X-ray Services</b></p>	<p>Provided. By Medicare-certified independent laboratories which have a signed participation agreement with the State agency. [Such services provided in a physician's office or in an X-ray facility owned and operated by a licensed physician are considered and paid as physicians' services.] No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable and customary charges as established by Medicare intermediary. Claims processed and paid by State Division of Welfare.</p>
<p><b>4. Skilled Nursing Home Services</b></p> <p><b>a. General</b></p> <p><b>b. In Institutions for Tuberculosis</b></p>	<p>Provided. Limited to persons age 21 or older. In institutions which have a signed participation agreement with the State agency. No limitations so long as patient is medically certified by a Division of Welfare medical consultant as needing such professional nursing care. Authority for vendor payment ceases upon determination that care in such institution is no longer required. (If patient eligible for public assistance continues to remain in the home, a budgeted amount up to \$125 may be included in the monthly money payment.) Reimbursement on basis of reasonable charge as determined by State agency. Claims processed and paid by State Division of Welfare.</p> <p>Provided. Limited to patients age 65 or older in State institutions which have entered into a participation agreement with the State agency. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost as determined by State agency. Claims processed and paid by State Division of Welfare.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to patients age 65 or older in State institutions which have entered into a participation agreement with the State agency. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost as determined by State agency. Claims processed and paid by State Division of Welfare.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. As furnished by a physician who has a signed participation agreement with the State agency. Payment for dispensed drugs limited to injectible medications which cannot be self-administered or when there are reasons why the medication cannot be taken orally. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charge as determined by State agency. Claims processed and paid by State Division of Welfare.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Limited to persons age 65 or older covered by State's buy-in agreement and to services received as Medicare benefits.
<b>b. Optometrists</b>	Not provided.
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing services. Limited to persons age 65 or older covered by State's buy-in agreement and to such services furnished by a home health agency when available as Medicare benefits.</p> <p>(b) Services of home health aide. Limited to persons age 65 or older covered by State's buy-in agreement and to such services furnished by a home health agency when available as Medicare benefits.</p> <p>(c) Medical supplies, equipment, and appliances. Limited to persons age 65 or older covered by State's buy-in agreement and to such items when received as Medicare benefits.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	Limited to persons age 65 or older covered by State's buy-in agreement and to such services when available as Medicare benefits.
<b>11. Dental Services</b>	Provided. When furnished by a dentist or the dental clinic of a school of dentistry having a signed participation agreement with the State agency. Limited to procedures and materials listed in State agency's "Schedule of Dental Services and Fees." Services not provided include orthodontia, treatment of pyorrhea and Vincent's infection, and the provision of partial dentures where none of the teeth to be replaced were extracted under the State agency's dental program. Prior authorization by State agency required for dentures, alveolectomies, removal of tori, root canal therapy, and any other procedure or course of treatment exceeding total expenditure of \$100. Reimbursement on basis of fee schedule. Claims processed and paid by State Division of Welfare.



**B. Medical and Remedial Care and Services (Continued)**

<b>12. Physical Therapy and Related Services</b>	
a. Physical Therapy	Limited to persons age 65 or older covered by State's buy-in agreement and to such services when available as Medicare benefits.
b. Occupational Therapy	Limited to persons age 65 or older covered by State's buy-in agreement and to such services when available as Medicare benefits.
c. Speech Therapy	Limited to persons age 65 or older covered by State's buy-in agreement and to such services when available as Medicare benefits.
d. Audiology	Not provided.
<b>13. Prescribed Drugs</b>	Provided. As furnished by pharmacist or other qualified provider having a written participation agreement with the State agency. Limited to legend drugs prescribed by physician or dentist, and to items, dosage strengths, and forms (liquid, tablet, etc.) listed in drug formulary. Restricted to original prescription and two refills, each of which may not exceed a 30-day supply except in extenuating circumstances, when a 90-day supply may be permitted. Non-legend drugs and medicine specifically excluded. No requirements for prior authorization. Reimbursement on basis of formulary price plus professional fee of \$1.00 and an additional 10¢ to cover cost of container. (For any drug priced generically in the formulary, no higher price paid regardless of trade name under which dispensed.) Claims processed and paid by State Division of Welfare.
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Not provided.
b. Hearing Aids	Not provided.
c. Dentures	Provided. Including full upper and lower dentures. Partial dentures limited to cases where at least some of the teeth to be replaced were extracted under the State agency's dental program. Prior authorization by State agency required. Reimbursement on basis of fee schedule. Claims processed and paid by State Division of Welfare.
d. Other Prosthetic Devices	Limited to persons age 65 or older covered by the State's buy-in agreement, and to such items when received as Medicare benefits.
<b>15. Family Planning Services</b>	Provided. Limited to physician's services and prescribed drugs listed in drug formulary. Birth-control devices not included. Reimbursement on variable basis according to provider utilized. Claims processed and paid by State Division of Welfare.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Not provided.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.





**C. Eligibility for Medical Assistance (Continued)**

<b>b. FFP Claimed in Administrative Costs Only</b>	<p style="text-align: center;"><i>Optional</i></p> <p>(1) Unemployable individuals who are receiving general relief.</p> <p>(2) Unemployable individuals who would be eligible for general relief except for a durational residence requirement.</p> <p>(3) All recipients of blind pension benefits.</p>
<b>4. Coverage of the Medically Needy</b>	<p>Not included.</p>
<b>5. Financial Criteria</b>  <b>a. For Categorically Needy Persons</b>  <b>b. For Medically Needy Persons</b>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>Not applicable.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>The State agency issues an identification card each month to all individuals and families certified as eligible for medical assistance. Expiration date (end of pay period) appears on face of card together with the name and identification number of each eligible person.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Director of the Bureau of Medical Services (a social worker) is directly responsible to the Director of the Division of Public Welfare. The full-time professional staff of the unit consists of 2 Medical Consultants (M.D. and D.O.), 3 Pharmaceutical Consultants, a Consultant on Hospitals and Nursing Homes (hospital administration), a Psychiatric Social Work Consultant, an Assistant Chief of Medical Services (social work), and a Medical Claims Supervisor (business). In addition there are 2 part-time Dental Consultants, 2 part-time Medical Consultants, and a part-time Psychiatrist.</p>
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of Statewide operations is accomplished through the general field staff of the Division of Welfare assigned to the 15 district offices and 6 urban counties (3 Field Supervisors, 6 Urban Supervisors, and 15 District Supervisors). Title XIX questions are cleared through the Bureau of Medical Services.</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Medical Advisory Committee to the Division of Welfare. It is composed of 20 members appointed by the Director, Division of Welfare. There are 7 ex officio members (the Executive Secretaries of the Missouri Association of Osteopathic Physicians and Surgeons, State Medical Association, Pharmaceutical Association, State Dental Association, Hospital Association, Association of Licensed Nursing Homes, and Optometric Association). Authority for the Committee is statutory.</p>
<b>4. Buy-In Agreement</b>	<p>State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.</p>
<b>5. Claims Payment Process</b>  <b>a. State and Local Agencies</b>  <b>b. Fiscal Agents</b>	<p>The State agency processes and pays all claims for services provided under the program.</p> <p>None.</p>

**D. Administration and Management (Continued)**

<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Missouri as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 59.29.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually to the Division of Welfare, specifically designated "for benefits under Title XIX." Unobligated balance may not be carried over at the end of the fiscal year.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, a supplemental appropriation must be obtained from the State legislature or the program be curtailed through a reduction in services and/or rates of payment.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

MONTANA

## A. General Information

1. Legal Base	Chapter 325, Montana Session Laws of 1967.
2. Beginning Dates	Program went into operation on July 1, 1967. Original plan approved by the Federal agency on September 29, 1967.
3. Administrative Responsibility	The State Department of Public Welfare serves as the single State agency with responsibility for supervising the administration of the program on a Statewide basis by local offices in the 56 counties of the State.
4. Historical Background	<p>Medical care for persons who are unable to pay for it has long been a county responsibility and the Montana Public Welfare Act originally made no provision for State financial participation in such costs. The first plan for payment of such costs by the State with Federal financial participation under the public assistance programs was limited to remedial eye care, that is, treatment to prevent blindness or restore sight, under the AB program, beginning in July 1957. The same services were extended to OAA, APTD, and AFDC recipients on July 1, 1958.</p> <p>In 1965, the Legislature authorized a program of general medical care for OAA recipients, beginning July 1, 1965. The same act authorized a program of Medical Assistance for the Aged (MAA), a Federal-State program for persons 65 years of age and older who were not recipients of public assistance but who met certain criteria of financial and medical need. The statute was in broad terms as to the kinds of services which might be given to aged persons under either program, leaving it to the State agency to define the scope of services in line with the funds available. The same services, in the main, were provided to both: inpatient hospital care, outpatient hospital services; laboratory and X-ray services up to \$75 per patient per year, nursing home care, physicians' services, pharmaceutical services (\$9 per month), special duty nursing in hospital, and home health care services of a visiting nurse. The programs for OAA and MAA were modified to some extent in 1966 to coordinate with the new program of Medicare under title XVIII.</p> <p>For the AB, APTD, and AFDC programs, the same services were listed as for the OAA program but were still restricted to services related to remedial eye care to prevent blindness or restore sight. (The cost of other kinds of medical services was met from General Assistance funds, which were administered by the same local welfare agencies under the supervision of the State welfare agency.)</p>
5. Scope of Coverage	Program provides coverage for categorically <sup>and medically</sup> needy persons only. (See Item C.3.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to categorically needy persons is equal in amount, duration, and scope for all individuals with the following exception:</p> <p>Certain services covered as benefits under Medicare are made available on a more liberal basis to individuals covered by the State's payment of the Part A deductible under title XVIII. (Item B.1.a.)</p>

## B. Medical and Remedial Care and Services

1. Inpatient Hospital Services	
a. In General Hospitals	<p>Provided. Limited to 7 days per admission with a 7-day extension after approval of the State Medical Consultant. By virtue of State's payment of the deductible under title XVIII, Part A, persons age 65 and older who are eligible for Medicare benefits are entitled to receive 60 days hospitalization. Persons age 65 and older who are not eligible for title XVIII benefits are limited to the 7 days plus 7 days extension. No requirements for prior authorization for days covered as Medicare benefits. Reimbursement on basis of reasonable cost. Claims processed by fiscal agent; (Montana Physician Services); paid by State Department of Public Welfare.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges.</p> <p>Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.</p>
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No limitations. No requirements for prior authorization, but social report on patient must be completed by caseworker at time of admission, and need for skilled nursing care be evidenced by a completed "Level of Care Evaluation" form, signed by the attending physician and one of the facility's nurses. Social report and level of care evaluation submitted to State department; payment not made for care rendered prior to date of nurse's signature. New evaluation chart must be submitted by the nursing home to the State welfare department every three months. Reimbursement on basis of rate (based on cost) negotiated with each individual nursing home. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of customary charges that are reasonable. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Not provided.
<b>b. Optometrists</b>	Provided. Limited to one visual examination and one pair of glasses per year; also, replacement of frame and/or lenses, with or without examination, once a year, instead of but not in addition to new glasses. Services may be provided by an optometrist or ophthalmologist. Prior authorization by State office required for contact lenses. Payment of all claims subject to approval by State Supervising Ophthalmologist. Reimbursement on basis of unit value fee schedule developed by State Optometric Association in 1967 (revised every 2 years). Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.



**B. Medical and Remedial Care and Services (Continued)**

<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. As prescribed by attending physician and furnished by certified home health agency to patient in own home. Combined total of all home health agency visits limited to 100 per year following at least 3-day stay in hospital or skilled nursing home, and 100 such visits without regard to previous institutional care. No requirements for prior authorization. Reimbursement on basis of reasonable cost (according to title XVIII principles and standards). Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.</p> <p>(b) Services of home health aid. Provided. As prescribed by attending physician and furnished by certified home health agency to patient in own home. Combined total of all home health agency visits limited to 100 per year following at least 3-day stay in hospital or skilled nursing home, and 100 such visits without regard to previous institutional care. No requirements for prior authorization. Reimbursement on basis of reasonable cost (according to title XVIII principles and standards). Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. Consisting of durable medical equipment (wheel chairs, walkers, etc.) and major sick room supplies, as recommended by attending physician. Prior authorization by State agency required. Reimbursement on basis of usual and customary retail rate. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Provided. Limited to services of registered nurses provided for a maximum of 14 days to hospital inpatients, upon request of attending physician. Prior authorization by State office required. Reimbursement on basis of \$26 per 8-hour shift. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>10. Clinic Services (Other than Hospital)</b>	Not provided.
<b>11. Dental Services</b>	Provided. Consisting of necessary extractions and fillings, treatment of acute infections, and emergency care for relief of pain; also, certain types of crowns, prophylactic procedures, fluoride treatment, and dentures. Orthodontia excluded. Prior authorization by State office required if services for one individual during a fiscal year cost more than \$40; except that the \$40 limit may be exceeded without prior authorization for emergency care. Reimbursement on basis of customary charges that are reasonable, based on the 83 percentile. Claims processed and paid by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. As furnished by certified home health agency or licensed physical therapist in private practice on the order of attending physician, up to 200 visits per year. No requirements for prior authorization. Reimbursement of home health agency on basis of reasonable cost (according to title XVIII principles and standards); of private-practicing therapist on basis of customary charges which are reasonable. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Occupational Therapy</b>	Provided. As furnished by certified home health agency or licensed occupational therapist in private practice on order of attending physician. Up to 200 visits per year. No requirements for prior authorization. Reimbursement of home health agency on basis of reasonable cost (according to title XVIII principles and standards); of private-practicing therapist on basis of customary charges which are reasonable. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>c. Speech Therapy</b>	Provided. As furnished by certified home health agency or licensed speech therapist in private practice on order of attending physician. Up to 200 visits per year. No requirements for prior authorization. Reimbursement of home health agency on basis of reasonable cost (according to title XVIII principles and standards); of private-practicing therapist on basis of customary charges which are reasonable. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>d. Audiology</b>	Provided. Limited to one examination per year. No requirements for prior authorization. Reimbursement on basis of customary charges which are reasonable. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs as prescribed by the physician. Limited to \$15 per month per recipient. No requirements for prior authorization. Reimbursement on basis of customary charges which are reasonable, but not to exceed the prevailing charges in the locality for comparable services under comparable circumstances. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. Limited to one pair of frames and lenses per year. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>b. Hearing Aids</b>	Not provided.
<b>c. Dentures</b>	Provided. No limitations. Prior authorization by State office required. Reimbursement on basis of usual and customary charge. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>d. Other Prosthetic Devices</b>	Provided. Must be recommended by attending physician. Consisting of prosthetic devices to replace all or part of a body organ; braces, artificial limbs, artificial eyes; and replacements as required by change in patient's condition. Orthopedic shoes provided only when attached to leg brace or other device. Prior authorization by State office required; request sent through caseworker at county welfare office. Reimbursement on basis of customary charges which are reasonable; price of each item negotiated on an individual basis by caseworker, physician, and vendor prior to submittal to State office for approval. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>15. Family Planning Services</b>	Provided. Upon recommendation of family physician. No limitations. No requirements for prior authorization. Reimbursement on basis of customary charges that are reasonable. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.
19. Personal Care Services In Patient's Home	Not provided.
20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services	Not provided.
21. Transportation  a. Ambulance          b. Other	<p>Provided. No limitations. No requirements for prior authorization, but must, except in emergencies, be recommended by attending physician. Payment made only to ambulance service certified by State Department of Health or Montana Ambulance Association. Reimbursement on basis of usual and customary charges. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.</p> <p>Provided. By train, bus, or taxicab. Including cost of an attendant, meals and lodgings enroute, and other related travel expenses when necessary. Must be recommended by attending physician or caseworker. No limitations. Prior authorization by State office required. Reimbursement on basis of 9 cents per mile or according to special negotiated arrangements approved by State agency. Claims processed by fiscal agent (Montana Physician Services); paid by State Department of Public Welfare.</p>

**C. Eligibility for Medical Assistance**

1. Date of Entitlement	Upon determination of eligibility an individual is retroactively entitled to assistance as early as 90 days prior to the date of application, provided all conditions of eligibility were met in the month in which services were rendered.
2. Conditions of Eligibility (By Age Groups)  a. Under Age 21	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p> <ol style="list-style-type: none"> <li>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</li> <li>(2) Child in AFDC foster care.</li> <li>(3) Child in foster home or private institution for whom the State department is assuming financial responsibility in whole or in part. [Including non-AFDC foster care.]</li> <li>(4) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</li> <li>(5) Person who is blind (State definition).</li> <li>(6) Person who is permanently and totally disabled (State definition) and age 18 or older.</li> <li>(7) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</li> </ol>

**C. Eligibility for Medical Assistance (Continued)**

<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or AFDC.</p>
<b>c. Age 65 or older</b>	<p>(1) Individual who has attained age 65.</p>
<b>3. Coverage of the Categorically Needy</b>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p>
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) All children under age 21 in foster homes or private institutions for whom the State department has assumed financial responsibility in whole or in part.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only.)</p>
<b>b. FFP Claimed in Administrative Costs Only</b>	<p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
<b>4. Coverage of the Medically Needy</b>	<p>Not included.</p>
<b>5. Financial Criteria</b>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p>
<b>a. For Categorically Needy Persons</b>	<p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>
<b>b. For Medically Needy Persons</b>	<p>Not applicable.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.</p>



**C. Eligibility for Medical Assistance (Continued)**

<b>7. Identification to Vendors of Persons Eligible</b>	A Medicaid Card is issued on a yearly basis by the local county welfare office to each individual and family group certified as eligible to receive medical assistance. It is reviewed each 6 months for AFDC. Face of card bears Household Number, date of issuance, and expiration date; reverse side lists the names and birth dates of all certified members of the family.
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**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Director (MSW) of the Division of Medical Assistance (the medical assistance unit) is directly responsible to the Administrator of the State Department of Public Welfare. Other full time professional staff consists of a Medical Facilities coordinator (field of hospital and nursing home administration) located in Billings, Montana, but directly responsible to the Director of the Division of Medical Assistance; Medical Care Specialist (MSW); and Medical Social Worker (MSW), both located in central office directly responsible to Division Director. In addition, the services of the following professional staff are available on a part-time basis: a physician, an ophthalmologist, an optometrist, a dentist, and an osteopath. Pharmaceutical consultation is available from 2 registered pharmacists without charge.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through field staff of the Department of Public Welfare.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the "Medical Assistance Advisory Council." It is composed of 9 members appointed by the Governor. One member is chosen to represent consumer interests, the others to represent 8 State professional associations, which are asked to submit the names of one or more recommended appointees. In addition, there are 2 ex officio members (Executive Director of the State Board of Health and the Administrator of the State Department of Public Welfare). Authority for the Council is statutory.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	State agency makes all payments to medical vendors for services provided under the program.
<b>b. Fiscal Agents</b>	State agency has entered into a contract with Montana Physicians' Service (Blue Shield) to serve as fiscal agent for the processing of all medical vendor claims for services provided under the program.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Montana as promulgated by the Secretary of Health, Education and Welfare for the period 7/1/69 to 6/30/71 is 64.72.
<b>2. State/Local Participation</b>	State and local funds are used to pay 50% each of the non-Federal share of program costs of both medical assistance and administration. In addition, for assistance to ward Indians and State cases (i.e., without county residence), State funds are used for 100% of the non-Federal share.

**E. Financing (Continued)**

<b>3. Source of State Funds</b>	State's share of program costs is derived from monies appropriated biennially to the Department of Public Welfare from the General Fund. Appropriation Act specifies amount appropriated for each of the two years of the biennium. Unexpended balance at end of first fiscal year automatically reappropriated to the Department by legislative act. Unexpended balance at end of the the biennium reverts to the General Fund.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, State agency must obtain a supplemental appropriation from the State legislature or arrange for curtailment of the program. In the event funds of an individual county are depleted so that it is unable to finance its share of costs, a grant-in-aid is made by the State in order to assure continuation of county participation in the program.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

NEBRASKA

## A. General Information

1. Legal Base	Chapter 397 (Legislative Bill No. 937), 1965 Regular Session approved August 18, 1965.
2. Beginning Dates	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on March 31, 1967.
3. Administrative Responsibility	The Department of Public Welfare serves as the single State agency with responsibility for supervising the administration of the program by the 93 County Divisions of Public Welfare.
4. Historical Background	<p>Vendor payments for medical care from State funds, with Federal financial participation, for recipients of public assistance began in October 1957. Prior to that time, medical care costs which exceeded what could be provided within the maximum on the money payment to the recipient for total needs had been met from county funds alone. The first services were inpatient hospital care for all four categories, nursing home care costs under OAA, AB, and APTD for amounts beyond the \$50 "board and room component" supplied within the money payment, and dental care for AFDC only. In 1963 the scope of services under the vendor payment program was expanded, in accordance with newly enacted legislation. In addition to inpatient hospital care, all categories received nursing home care, services of physicians and certain other licensed practitioners, dental care including dentures, prescribed drugs, and artificial eyes or limbs.</p> <p>Also in 1963 the State Legislature authorized a program of Medical Assistance for the Aged (MAA) a Federal-State program for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. Services began under the program January 1, 1964. At first an applicant was obligated to pay, within each 6-month period, the first \$65 of inpatient hospital care or outpatient hospital services (but only one deductible if both were needed in one 6-month period) and the first \$35 of costs of care received from other vendors of medical services. The program did not cover nursing home care. Legislation in 1965 decreased the hospital deductible to \$35, revised the time period to "within each 12-month period", and added nursing home care to the scope of services. These liberalizations went into effect May 1965. Eligibility was also liberalized by raising the maximum on the level of income permitted. The program continued in operation until the beginning of medical assistance under title XIX.</p>
5. Scope of Coverage	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.; B.4.b. and c.).</p> <p>Services in skilled nursing homes are provided only for persons 18 years of age or older. (Item B.4.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Item B.12.b.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	<p>Provided. Unlimited except for exclusion of hospitalization associated with hemodialysis and organ transplants. No requirements for prior authorization for services received by persons age 65 or older as a Medicare benefit. For others, prior authorization by State office required for continuation of stay beyond a consecutive 3-month period; request to State or local office must be submitted prior to or within first 10 days of continuance. Reimbursement on basis of maximum per diem rate established by State agency upon audit of hospital's certified annual "Statement of Reimbursable Cost Report." Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>b. In Institutions for Tuberculosis</b>	<p>Provided. Limited to patients age 65 or older in public or private institutions. No other limitations. No requirements for prior authorization. Reimbursement at negotiated per diem rate based on cost of operation. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to patients age 65 or older in public or private institutions. No other limitations. No requirements for prior authorization. Reimbursement at negotiated per diem rate based on cost of operation. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of maximum per visit rates established by audit. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	<p>Provided. Limited to persons age 18 or older. No limitations. No requirements for prior authorization. Reimbursement on basis of classification of care and established maximum payments. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>b. In Institutions for Tuberculosis</b>	<p>Provided. Limited to patients age 65 or older. No limitations. No requirements for prior authorization. Reimbursement on basis of classification of care and established maximum payments. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to patients age 65 or older. No limitations. No requirements for prior authorization. Reimbursement on basis of classification of care and established maximum payments. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Provided. Based upon need and caseworker evaluation of need. Reimbursement at usual and customary charges. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. Excluding services associated with hemodialysis or organ transplants. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges; payment to M.D.'s not to exceed \$5 per unit of Nebraska State Medical Association's 1965 Relative Value Study (for psychiatric physician, not to exceed one value unit per day); payment to osteopaths not to exceed maximum fee schedule. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>



**B. Medical and Remedial Care and Services (Continued)**

<p><b>7. Services of Licensed Practitioners</b></p> <p><b>a. Podiatrists</b></p> <p><b>b. Optometrists</b></p> <p><b>c. Chiropractors</b></p> <p><b>d. Other</b></p>	<p>Provided. All services authorized within podiatry licensure. No limitations. No requirements for prior authorization. Reimbursement for palliative treatment on basis of maximum fee schedule; of all other services on basis of Nebraska State Medical Association's 1965 Relative Value Study (\$5 per unit value). Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p> <p>Provided. Limited to examination, prescription for and provision of glasses, and repair of glasses. Approval of State office required for provision and cost of contact lenses. Reimbursement on basis of maximum fee schedule stating all-inclusive rate for services, lenses, and frames; portion of rate allowed for services alone or glasses alone designated by county office. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p> <p>Provided. Limited to examination and spinal manipulation, plus one set of X-rays for any individual in a 12-month period. No requirements for prior authorization. Reimbursement on basis of maximum fee schedule. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p> <p>Not provided.</p>
<p><b>8. Home Health Care Services</b></p>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided. As recommended by physician and furnished by certified home health agency, RN, LPN, or Visiting Nurse Association. No limitations. No requirements for prior authorization. Reimbursement of home health agency on basis of reasonable cost (audited cost rates established by Medicare); of RN, LPN, or Visiting Nurse Association on basis of maximum fee schedule. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p> <p>(b) Services of home health aide. Provided. As recommended by physician and furnished by certified home health agency. No limitations. No requirements for prior authorization. Reimbursement of home health agency on basis of reasonable cost (audited cost rates established by Medicare). Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p> <p>[NOTE: "Home Health Aide Services" furnished by a self-employed individual as described in State Manual Section 6561 appears in this publication as Item B.19.]</p> <p>(c) Medical supplies, equipment, and appliances. Provided. When recommended by physician. All supplies listed in Medical Supply Section of "Official Drug Pricing Guide"; rental or purchase of durable medical equipment, medical appliances, or devices (wheel chairs, walkers, crutches, etc). No limitations; requirement for prior State Department authorization of purchase over \$250. Reimbursement for medical supplies on basis of usual and customary charge in the community; of equipment and appliances on basis of percentage discount on usual and customary charges. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<p><b>9. Private Duty Nursing Services (RN or LPN)</b></p>	<p>Provided. Upon recommendation of attending physician. In patient's home, or elsewhere. No limitations. No requirements for prior authorization. Reimbursement on basis of maximum fee schedule. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. Services rendered by licensed practitioners through a clinic which is not part of a hospital complex (excluding payment for bed or board). No limitations. No requirements for prior authorization. Reimbursement to clinic on basis of usual and customary charges with payment for physician not to exceed \$5 per unit of Nebraska State Medical Association's 1965 Relative Value Study (for psychiatric physician, not to exceed one value unit per day); for osteopaths, not to exceed maximum fee schedule. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>11. Dental Services</b>	<p>Provided. No limitations. Prior authorization by county office required for all services except emergency care, preliminary examinations, and diagnostic evaluations (for services costing over \$40, authorization must be in writing). Authorization by State office required prior to provision of services when dental care program proposed for patient includes orthodontia, surgery (other than extractions), hospitalization, or dentures (full or partial), or when cost exceeds \$200. All dental work must be completed within 90 days from date of authorization; special dispensation may be granted by State Department for orthodontic cases. No payment for additional dental services within one year from date of last authorized service, except in emergencies. Reimbursement on basis of usual and customary charges; payment not to exceed negotiated State maximum of 10¢ per unit of value. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>12. Physical Therapy and Related Services</b>	<p><b>a. Physical Therapy</b></p> <p>Provided. On physician's recommendation. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges not in excess of State's negotiated maximum fee schedule. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p> <p><b>b. Occupational Therapy</b></p> <p>Provided. On physician's recommendation. Limited to persons age 65 or older covered by State's buy-in agreement when received as Medicare benefit. No requirements for prior authorization. Reimbursement of deductible and co-insurance. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p> <p><b>c. Speech Therapy</b></p> <p>Provided. On physician's recommendation. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges not in excess of State's negotiated maximum fee schedule. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p> <p><b>d. Audiology</b></p> <p>Provided. On physician's recommendation. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>13. Prescribed Drugs</b>	<p>Provided. Legend and non-legend drugs. As prescribed by a licensed practitioner. Authorization by county office required prior to dispensing of over-the-counter drugs not listed in "Official Drug Pricing Guide." Reimbursement for legend drugs on basis of acquisition cost from wholesaler plus dispensing fee of \$1.75; of non-legend drugs on basis of usual and customary charge in the community, not to exceed listed maximum price in over-the-counter section of "Official Pricing Guide." Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>
<b>14. Prosthetic Devices</b>	<p><b>a. Eyeglasses</b></p> <p>Provided. No limitations. Approval of State office required for provision of contact lenses and determination of allowable cost. No other requirements for prior authorization. Reimbursement on basis of maximum fee schedule stating all-inclusive rate for services, lenses, and frames; portion of rate allowed for service alone or glasses alone designated by county office. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>b. Hearing Aids</b>	Provided. Purchase and maintenance of hearing aids, including batteries and other supplies. As recommended by a practitioner licensed to treat conditions warranting the use of such items. No limitations. Approval of State office prior to purchase required for hearing aid costing in excess of \$250. Reimbursement on basis of usual and customary charge in the community. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.
<b>c. Dentures</b>	Provided. Full and partial dentures, including relining and repair of used dentures when necessary. No limitations. Authorization by State office required prior to provision of new dentures. Reimbursement on basis of usual and customary charges; payment not to exceed negotiated State maximum of 10¢ per unit of value. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.
<b>d. Other Prosthetic Devices</b>	Provided. Purchase and maintenance of appliances to replace a missing part of the body (exclusive of organ transplants), including artificial limbs, artificial eyes, and joint prostheses. If recommended by a physician. No limitations. Approval by State office prior to purchase required for prosthetic appliances costing over \$250. Reimbursement on basis of usual and customary charge. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.
<b>15. Family Planning Services</b>	Provided. Physicians' services, drugs, supplies, and devices. No payments to family planning organizations for consultation or for materials dispensed. No requirements for prior authorization. Reimbursement to physician on basis of usual, customary, and reasonable charge; to pharmacist on basis of listed maximum price in over-the-counter section of "Official Pricing Guide." Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. For period of time necessary until patient can safely be moved elsewhere without danger to life or impairment of health. Reimbursement on basis of per diem rate established by audit. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.
<b>19. Personal Care Services In Patient's Home</b>	Provided. Personal care furnished to patient in own home, if needed to continue a medical treatment plan. As rendered by a nonprofessional person (who is not a relative in the home of the patient) in accordance with attending physician's recommendation and under his supervision or that of a registered nurse. No limitations. No requirements for prior authorization. Reimbursement on basis of \$1.60 per hour, within maximum of \$10 per day. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. Excluding screening services. Psychiatric services, psychological testing, and care in an extended care facility are provided. Basis of reimbursement variable according to provider furnishing the services and applicable maximum fee schedules. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. In emergencies due to accident or sudden illness and when patient's condition precludes use of other means of transportation. No limitations. No requirements for prior authorization. Reimbursement on basis of charges not in excess of going rate in community. Claims partially processed by County Division of Public Welfare; final processing and payment by State Department of Public Welfare.

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Other</b>	<p>Not provided.</p> <p>[Cost of transportation required to obtain approved medical care or services may be included in the budget of a recipient of AABD or AFDC; also cost of meals and lodgings up to a maximum of \$8 per day if such travel involves the recipient's being away from home for more than 12 hours.]</p>
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**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as 30 days prior to the date of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>  <b>a. Under age 21</b>          <b>b. Age 21 to 64</b>          <b>c. Age 65 or older</b>	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p> <p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition) and age 16 or older.</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition)</p> <p>(1) Individual who has attained age 65.</p>
<b>3. Coverage of the Categorically Needy</b>    <b>a. FFP Claimed in Medical and Administrative Costs</b>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of AABD and AFDC.</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p>



## C. Eligibility for Medical Assistance (Continued)

<p>a. FFP Claimed in Medical and Administrative Costs—Continued</p>	<p style="text-align: center;"><i>Optional</i></p> <p>(1) Persons eligible for but not receiving AABD or AFDC.</p> <p>(2) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(3) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p>
<p>b. FFP Claimed in Administrative Costs Only</p>	<p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
<p>4. Coverage of the Medically Needy</p>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a., above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess, in accordance with the regulations.</p>
<p>5. Financial Criteria</p> <p>a. For Categorically Needy Persons</p> <p>b. For Medically Needy Persons</p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>(1) <i>Income</i></p> <p>Annual income which may be retained for basic maintenance needs: \$1600 for one person, \$2200 for family of 2, \$2600 for 3, \$3000 for 4, and \$400 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$10 a month for personal expenses, plus \$5 per month if needed for guardianship or conservatorship fee. If no spouse or dependent child remains in the home, an additional amount may be allowed for up to one year to cover costs of home ownership. Additional income may be applied to maintenance needs of dependents up to \$1600 per year for one dependent, \$2200 for 2 dependents, and higher amounts for additional dependents (according to progression stated in previous paragraph).</p> <p>(2) <i>Resources</i></p> <p>Home occupied as a residence may be retained regardless of value or equity.</p> <p>Household furnishings and personal property are exempt up to a reasonable value.</p> <p>Other resources may be retained within the following limitations on worth (determined on basis of current market value):</p> <ul style="list-style-type: none"> <li>(a) Real and personal property (including automobile, non-home real property, and property used in producing income up to net value of \$3000). (Excess applied to liquid reserve described in (c).)</li> <li>(b) Life insurance per person up to cash surrender value of \$1000 each. (Excess applied to liquid reserve described in (c).)</li> <li>(c) Liquid reserves up to \$750 for one person, \$1500 for 2, plus \$25 for each additional person.</li> </ul> <p>Resources in excess of these amounts disqualify applicant from receiving medical assistance under the program.</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21.
<b>7. Identification to Vendors of Persons Eligible</b>	Nebraska does not use a separate medical identification card system. State agency issues a "Certificate of Award" to each money-payment and non-money-payment case certified or recertified as eligible, which may be used by recipient as evidence of eligibility.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Chief of the Division of Medical Services (field of Public Health) is directly responsible to the State Director of Public Welfare. There is a full-time professional staff of a Medical Social Work Consultant, Psychiatric Social Work Consultant, Pharmaceutical Consultant, and Public Health Nursing Consultant. In addition there are part-time consultants in medicine, psychiatry, dentistry and otolaryngology. The Health Care Representative is used especially to assist in interpreting the program to county staff members or providers of Medical Services.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through two consultants (medical and pharmacy) in the Division of Medical Services who serve on a Statewide basis, Field Supervisors of the general field staff of the agency who are assigned to the supervisory districts, and a Health Care Representative.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Assistance Advisory Committee. It is composed of 23 members appointed by the Governor upon recommendation of the State Director of Public Welfare. There is one ex officio member (State Director of Public Welfare). Authority for the Committee is administrative.
<b>4. Buy-in Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money-payment recipients age 65 or older, who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	Claims from providers of all kinds of medical care and services under the plan are partially processed by the county Division of Public Welfare with final processing and payment by State Department of Public Welfare.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Nebraska as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 57.25.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of administration, and State and local funds are used to pay 50% of the non-Federal share of medical care costs. State funds are used for 100% of the non-Federal medical care costs for non-residents, persons without county settlement, and "recipients who have a right of residence on any reservation under the jurisdiction of the U.S. Government." If a county is unable to pay its share of costs from the county levy for the purpose, the State will pay the local share.



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**E. Financing (Continued)**

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<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially from the State's general fund. Unobligated balance may be carried over within the biennium but reverts to the General Fund at the end unless reappropriated.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, an emergency appropriation may be arranged. If this is not possible, all services (except hospital care by State statute) are cut by a specified percent, after a public hearing.

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## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health, Welfare, and  
Rehabilitation (Welfare Division)

January 1, 1970

NEVADA

A. General Information	
1. Legal Base	Nevada Revised Statutes (1967), Vol. 13, Title 38, Chapter 428.
2. Beginning Dates	Program went into operation on July 1, 1967. Original plan approved by the Federal agency on September 13, 1967.
3. Administrative Responsibility	The State Department of Health, Welfare and Rehabilitation through the Welfare Division serves as the single State agency with responsibility for administering the program on a State-wide basis through a system of local offices.
4. Historical Background	<p>Vendor payments for medical care were used in the Federal-State public assistance program as early as October 1, 1951, for a limited scope of medical services for recipients of OAA only. But in 1957 a law was enacted authorizing the purchase of medical care or any type of remedial services under the OAA and AB programs. (AFDC was not included; and the State has no APTD program.) Accordingly, a group pre-payment contract was made with the State Medical Association for "appropriate care". Later, contracts were made with the State Optometric Association and the Washoe County Medical Society. The professional associations had responsibility for "setting fee schedules, proration of payment when necessary, audit, and medical review of medical, dental, optometric, and pharmaceutical services and practice." A monthly capitation payment was made by the State Welfare Department for each recipient of OAA and AB. The scope of services included physicians' services and services of podiatrists and (for OAA only) optometrists, dental care, prescribed drugs, and X-ray services. Prosthetic appliances were paid for by vendor payments directly to the suppliers; and allowances were made for nursing home care through the money payment to the recipient for subsistence needs. Inpatient hospital care was not paid for under the public assistance categories.</p> <p>In 1961, after Federal financial participation in vendor payments for medical care under OAA was liberalized, eligibility for medical care was extended to persons otherwise eligible for OAA or AB who had enough income to meet subsistence needs but not enough to meet the cost of necessary medical care. In January 1962, the use of vendor payments was extended to nursing home care, services of visiting nurses, or services of home health aides. These services were outside the contract arrangement and were paid by the Welfare Department directly to the suppliers.</p> <p>In 1963, special legislation authorized the purchase of medical and remedial care for AFDC recipients. The services, beginning July 1, 1963, were limited to outpatient services of physicians and pharmaceutical services. A capitation payment was made monthly for each recipient, under the contract with the State Medical Association.</p> <p>The Federal-State program of Medical Assistance for the Aged (MAA) was implemented by Nevada July 1, 1965. This program was designed for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. The services provided included those provided under OAA plus inpatient hospital care for acute illness or injury. All former "medical only" cases under OAA, and those age 65 and older under AB, were transferred to the MAA program. The programs under MAA and the public assistance categories continued until the beginning of the medical assistance program under title XIX.</p>
5. Scope of Coverage	Program provides coverage for categorically needy persons only. (See Item C.3.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c; B.4.b. and c.)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p>



**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
a. In General Hospitals	Provided. No limitations. Prior authorization by State office required (unless care received is compensable under Medicare) when admission is for purpose of receiving elective surgery, and for any extension of inpatient care beyond initial period of 15 days. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
b. In Institutions for Tuberculosis	Provided. Limited to patients age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
c. In Institutions for Mental Diseases	Provided. Limited to patients age 65 or older in the State Mental Hospital. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. Prior authorization by State office required (unless care received is compensable under Medicare) for laboratory and/or X-ray services costing in excess of \$25. Reimbursement on basis of maximum fee established by application of 5.5 conversion factor to 1964 California Relative Value Studies. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. Prior authorization by State office required (unless services received are compensable under Medicare) for laboratory and/or X-ray services costing in excess of \$25. No requirements for prior authorization. Reimbursement on basis of maximum fee established by application of 5.5 conversion factor to 1964 California Relative Value Studies. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>4. Skilled Nursing Home Services</b>	
a. General	Provided. Limited to persons age 21 or older. No other limitations. Prior authorization by State office required except for first 20 days of admission which follows hospitalization and for any services received in an extended care facility when compensable under Medicare. Reimbursement on basis of negotiated rate. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
b. In Institutions for Tuberculosis	Provided. Limited to patients age 65 or older in public or private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
c. In Institutions for Mental Diseases	Provided. Limited to patients age 65 or older in State Mental Hospital. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. Prior authorization by State office required (unless services received are compensable under Medicare) for (1) non-emergency inpatient medical and surgical procedures when fee exceeds \$200, (2) home and/or office visits exceeding 3 per month, (3) psychiatric evaluations and treatments, and (4) referrals for consultation. Reimbursement on basis of usual and customary charges not to exceed maximum fee established by application of 5.5 conversion factor to 1964 California Relative Value Studies. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).

**B. Medical and Remedial Care and Services (Continued)**

<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>  <b>b. Optometrists</b>  <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Provided. As prescribed by a physician. No limitations. Prior authorization by State office required (unless services received are compensable under Medicare). Reimbursement on basis of fee schedule. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).</p> <p>Provided. No limitations. Prior authorization by State office required. Reimbursement on basis of fee schedule. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).</p> <p>Not provided.</p> <p>Provided. Services of licensed psychologist. No limitations. Prior authorization by State office required, after review and evaluation of medical need and social situation. Reimbursement on basis of usual and customary charges up to set fee schedule. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).</p>
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided. As furnished by home health agency, visiting nurse association, or independent RN or LPN. No limitations. Prior authorization by State office required (unless services received are compensable under Medicare). Reimbursement of home health agency and visiting nurse association on basis of reasonable cost; of independent RN or LPN on basis of fee schedule. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).</p> <p>(b) Services of home health aide. Provided. As furnished by home health agency. No limitations. Prior authorization by State office required (unless services received are compensable under Medicare). Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations. Prior authorization by State office required (unless items received are compensable under Medicare) where cost exceeds \$15. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Provided. In hospital, skilled nursing home, or patient's own home. No limitations. Prior authorization by State office required (except in emergencies), after review and evaluation. Reimbursement on basis of fee schedule. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. Including preventive, rehabilitative, therapeutic, or palliative items or services furnished under the direction of a physician. No limitations. Prior authorization as required for physician's service, dental service, home health care, laboratory and X-ray service and physical therapy. Reimbursement on basis of fee schedule or California Relative Value Schedule. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).</p>
<b>11. Dental Services</b>	<p>Provided. Including orthodontia in cases approved after review and evaluation. No limitations. Prior authorization by State office required for all dental services except emergency treatment for relief of pain or infection when fee is \$15 or less. Reimbursement on basis of fee schedule. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. As prescribed by a physician and furnished by private practicing therapist, home health agency, or other qualified provider. No limitations. Prior authorization by State office required (unless services received are compensable under Medicare). Reimbursement on basis of maximum fee established by application of 5.5 conversion factor to 1964 California Relative Value Studies. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>b. Occupational Therapy</b>	Not provided.
<b>c. Speech Therapy</b>	Not provided.
<b>d. Audiology</b>	Not provided.
<b>13. Prescribed Drugs</b>	Provided. Non-legend drugs limited to insulin (including syringes and needles). Prior authorization by State office required for single prescription costing in excess of \$15. Reimbursement of prescription at "unit cost" plus 50% plus 50¢, with additional 8¢ per minute for time needed to fill compounded prescription. ("Unit cost" defined as wholesale cost per pint, per pound, per capsule, per tablet, etc., according to Red Book or Blue Book.) \$1.25 minimum reimbursement per prescription. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. Including repair and replacement of lenses and frames. Excluding sub-normal visual aids, contact lenses, sunglasses, artificial eyes, and recumbent glasses. Prior authorization by State office required. Reimbursement on basis of fee schedule. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>b. Hearing Aids</b>	Provided. When hearing loss is established by a licensed physician. Including batteries and other supplies. Limit of \$180 payment for hearing aid. Prior authorization by State office required. Reimbursement on basis of fee schedule. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>c. Dentures</b>	Provided. No limitations. Prior authorization by State office required. Reimbursement on basis of fee schedule. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>d. Other Prosthetic Devices</b>	Provided. As required by physician. Artificial limbs, artificial eyes, and other prosthetic devices which replace or aid a part of the human body in carrying on its normal function (as listed in California Department of Finance Medical and Related Services Manual). Prior authorization by State office required. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices, when services are under supervision of a physician. No limitations. Prior authorization by State office required for physician's visits in excess of 3 per month, for drug prescriptions, supplies, and devices exceeding cost of \$15. Reimbursement variable according to provider utilized. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. When necessary to prevent death or serious impairment of health. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>19. Personal Care Services In Patient's Home</b>	Provided. Personal care services in a recipient's home prescribed by a physician in accordance with a plan of treatment and rendered by an individual, not a member of the family, certified by a physician as being qualified to perform such services. No limitations. Prior authorization by State office required; arrangements for such care usually made by caseworker. Reimbursement to individual performing such services at rate of \$1.75 per hour: Home Health Aide Services at audited reasonable costs. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. Upon order of a physician or in an emergency when necessary to protect the health of the patient. No limitations. Prior authorization by local caseworker required except in emergencies or when services received are compensable under Medicare. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).
<b>b. Other</b>	Provided. By common carrier, taxi, private automobile, or other appropriate means. Including cost of meals and lodgings enroute, and cost of an attendant if necessary for medical or other reasons. No limitations. Prior authorization by State office required for transportation between urban centers; by local caseworker for transportation to or within an urban area. Reimbursement of taxicab as charged; of common carrier on basis of usual and customary charges to the general public; of private vehicle on basis of 10¢ per mile; of maintenance needs during trip away from home at actual cost not to exceed \$20 per day. Claims processed and paid by fiscal agent (Nevada Blue Shield Plan).

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month of application, but only the time for which the person is determined to have been otherwise eligible during the period preceding the approval date.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Child in foster home or private institution for whom a public agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care)</p> <p>(4) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(5) Person who is blind (State definition).</p> <p>(6) Person who is permanently and totally disabled (State definition for title XIX purposes).</p>
<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  (Parent or relative not eligible unless child meets State's plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition for title XIX purposes).</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.



**C. Eligibility for Medical Assistance (Continued)**

<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, and AFDC. [State has not implemented an APTD program.]</p> <p>(2) Persons who would be eligible for OAA, AB, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) All children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part.</p> <p>(7) Persons who would be receiving assistance if the State had a program for APTD. (Special definition of permanent and total disability established by State agency for title XIX purposes.)</p>
<b>b. FFP Claimed in Administrative Costs Only</b>	<p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
<b>4. Coverage of the Medically Needy</b>	Not included.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	Not applicable.
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.
<b>7. Identification to Vendors of Persons Eligible</b>	A Medical Assistance Identification Card is issued monthly as a detachable part of the assistance check. In the case of persons eligible for medical assistance only, the check part is blank. Card shows name of recipient and lists names of other members of the family who are certified as eligible for medical assistance. Card is valid for month of issuance only.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Chief of Medical Services Branch (from field of Medical Administration) is directly responsible to the Administrator of the State Welfare Division. The full-time professional staff of the unit consists of: a physician (M.D.), a nurse (RN), a Social Service Specialist (Medical Social Work), and a Psychiatric Social Services Specialist (Psychiatric Social Work).
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**D. Administration and Management (Continued)**

<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the general field staff of the Division of Welfare.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Care Advisory Group. It is composed of 35 members appointed by the Governor. There are two ex officio members (State Budget Director and Chairman, Legislative Commission). Authority for the Advisory Group is administrative.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State agency is not directly involved in the processing and payment of claims from providers of medical care but carries this responsibility by contract with a fiscal agent.
<b>b. Fiscal Agents</b>	Claims from providers of all the kinds of services encompassed in the medical assistance plan are processed and paid by the fiscal agent under contract (Nevada Blue Shield Plan).
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Nevada as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.00.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially from the State's general funds and from earmarked tax funds specifically for title XIX costs, and all counties are required to deposit 11¢ of each county's ad valorem tax rate into such fund. Unobligated balance may be carried over within the biennium but reverts to the General Fund at the end.
<b>4. Deficit Financing</b>	Deficit spending is not allowed under State law.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health and Welfare

January 1, 1970

NEW HAMPSHIRE

**A. General Information**

<b>1. Legal Base</b>	Chapters 126-A, 161, and 167, New Hampshire Revised Statutes Annotated.
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1967. Original plan approved by the Federal agency on October 31, 1967.
<b>3. Administrative Responsibility</b>	The Department of Health and Welfare serves as the single State agency with responsibility for administering the program on a Statewide basis. Pursuant to delegation of authority within the Department, the program is directly administered by the Division of Welfare Services through its 11 District offices.
<b>4. Historical Background</b>	<p>Provisions for the use of vendor payments for some portion of the costs of medical care under the Federal-State public assistance programs began June 1, 1951, for OAA, AB, and AFDC and March 1, 1952, for APTD. The State used a "pooled fund" into which per capita payments were made each month for recipients of assistance under all four programs until 1964. There was a broad scope of services, implementing the State statute which provided for preventive, curative, palliative, and rehabilitative care. However, beginning in 1964, nursing home care costs were met through the money payment to the recipient rather than by vendor payments.</p> <p>In September 1961 the State began a Federal-State program of Medical Assistance for the Aged, for persons age 65 and older who were not recipients of public assistance but who met certain criteria of medical and financial need. The services under this program at first were only in-patient hospital care and physicians' services, both with limitations on amount which were subsequently liberalized in 1962. In 1963, outpatient laboratory services and X-ray services in a hospital setting or in a physician's office were added to the program. From the first, the program did not cover treatment for eye conditions because such care was available through the Sight Conservation Division of the Agency for persons who could not pay. Then in 1964, the MAA program was broadened to include medical treatment for diseases or injuries of the eye, including surgery and hospitalization. That same year the scope of services was amended to include prescribed drugs up to \$10 per month. The program continued until the implementation of the title XIX program.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services provided for categorically needy persons are not made available to medically needy persons. (Items B.7.d.; B.8.(a),(b), and (c); B.12.a.,b.,c., and d.; B.14.b.,c., and d.; B.15,16,17,19, and 20.)</p> <p>Certain services are available on a more liberal basis for persons age 65 or older than for others, when received as Medicare benefits. (Items B.6.; B.7.a.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Including payment for private room if medically necessary. No limitations. Prior authorization by State office required for more than 21 days in any one illness, except for services received as Medicare benefits by patients age 65 or older. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</p> <p>Not provided.</p> <p>Not provided.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to persons age 21 or older. No other limitations. Prior authorization by State office required, except for services received as Medicare benefits by person age 65 or older. Reimbursement on basis of reasonable cost; maximum rate recognized for payment not to exceed the prevailing Medicare rate for nursing home providing the service. Claims processed and paid by State Department of Health and Welfare.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc. for Individuals Under Age 21</b>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. Unlimited services for persons age 65 or older when received as Medicare benefits; otherwise, subject to the following limitations: (1) Visits to hospital inpatients limited to 30 calls in a 30-day period, (2) Psychiatrist's services to one person not to exceed cost of \$500 (including private insurance benefits) per fiscal year, and (3) for medically needy persons, services of ophthalmologist limited to surgery and post-surgical treatment for diseased eye condition. Prior authorization by State office required for psychiatrists' services. No other requirements for prior authorization. Reimbursement on basis of 20% less than usual and customary charges. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Excluding treatment of flat foot conditions, subluxations of the foot, and routine foot care. Other services unlimited for persons age 65 or older when received as Medicare benefits. For others, limited to 24 visits per fiscal year. No requirements for prior authorization. Reimbursement on basis of 20% less than usual and customary charges (as determined from profiles developed by Blue Cross). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).
<b>b. Optometrists</b>	Provided. No limitations. Prior authorization by State office required for services and items not listed on Ophthalmic Fee Schedule. Invoice of laboratory costs of materials and appliances must be attached to billing form. Reimbursement on basis of Ophthalmic Fee Schedule (contains allowance for professional services that can be recognized in addition to laboratory cost of the appliances). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).
<b>c. Chiropractors</b>	Provided. Limited to 24 visits per fiscal year. No requirements for prior authorization. Reimbursement on basis of 20% of reasonable charges as evaluated and approved by fiscal agent. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).
<b>d. Other</b>	Provided. Services of a certified clinical psychologist. For categorically needy persons only. Limited to maximum of \$500 per fiscal year per patient. Prior authorization by State office required for treatment, not to exceed 4 visits for each period of treatment approved. Except: Prior authorization not required for treatment and/or psychological evaluation when requested or directed by a psychiatrist as part of psychotherapeutic treatment. Reimbursement on basis of reasonable charge as evaluated and approved by fiscal agent. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <ul style="list-style-type: none"> <li>(a) Intermittent or part-time nursing. Provided. As furnished by home health agency or (when no such agency is available) by RN or LPN. No other limitations. Prior authorization by State office required for services of RN or LPN in independent practice. Reimbursement of home health agency on basis of reasonable cost; of independent RN or LPN on basis of established recognized payment schedule (as developed by the appropriate State nursing association). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</li> <li>(b) Services of home health aide. Provided. As furnished by home health agency. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</li> <li>(c) Medical supplies, equipment, and appliances. Provided. Physician's prescription required. No requirements for prior authorization if received as Medicare benefits by persons age 65 or older. Otherwise, prior authorization required as follows: For medical supplies, authorization by State office with approval granted for period not to exceed 6 months at any one time; authorization by District office required for appliance and for rental or purchase of equipment costing \$75 or less, or by State office if cost exceeds \$75. Reimbursement to pharmacy for medical supplies on basis of usual retail price (including any special sales prices available to the general public). Reimbursement for appliances and equipment on basis of individual rate negotiated with supplier. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</li> </ul>

**B. Medical and Remedial Care and Services (Continued)**

<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Provided. Limited to services provided to hospital inpatients. No other limitations, but medical necessity must be substantiated in writing by hospital or attending physician. Prior authorization by State office required, with approval granted for specific period of time. Reimbursement on basis of established recognized payment schedule (as developed by the appropriate State nursing associations). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. In clinics approved for participation in Medicare program. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charges as approved by fiscal agent. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</p>
<b>11. Dental Services</b>	<p>Provided. No limitations. Prior authorization by fiscal agent's dental consultant required for procedures and materials not listed in schedule of basic dental services; for orthodontia, additional approval of State office required in terms of social casework aspects of patient's condition. Reimbursement to participating dentist on basis of usual and customary charges, up to State prevailing level; for non-participating dentist, on basis of a "mean fee." Claims processed and paid by State Department of Health and Welfare.</p>
<b>12. Physical Therapy and Related Services</b>  <b>a. Physical Therapy</b>   <b>b. Occupational Therapy</b>   <b>c. Speech Therapy</b>   <b>d. Audiology</b>	<p>Provided. For categorically needy persons only. No limitations, but must be on physician's prescription. Prior authorization by district office required; not more than 2 months' service approved at one time. Reimbursement of home health agency on basis of reasonable cost; of private practicing therapist on basis of reasonable charge as evaluated and approved by fiscal agent. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</p> <p>Provided. For categorically needy persons only. No limitations, but must be on physician's prescription. Prior authorization by district office required; not more than 2 months' service approved at one time. Reimbursement of home health agency on basis of reasonable charge as evaluated and approved by fiscal agent. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</p> <p>Provided. For categorically needy persons only. No limitations, but must be on physician's prescription. Prior authorization by district office required; not more than 2 months' service approved at one time. Reimbursement of private practicing therapist on basis of reasonable charge as evaluated and approved by fiscal agent. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</p> <p>Provided. For categorically needy persons only. No other limitations, but must be on physician's prescription. Prior authorization by district office required; not more than 2 months' service approved at one time. Reimbursement of private practicing therapist on basis of reasonable charge as evaluated and approved by fiscal agent. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).</p>
<b>13. Prescribed Drugs</b>	<p>Provided. Legend and non-legend drugs. Limited to 5 refills during a 6-month period on original prescription for legend drug. New prescription on maintenance drugs required every 6 months. No requirements for prior authorization for legend drugs nor for insulin and insulin-related supplies. Written prior approval by State office required for all other non-legend medications and medical supplies, based upon written request of attending physician. Reimbursement for legend drugs on basis of wholesale price as listed in Red Book for nearest package unit plus a professional fee of \$1.85 per prescription; for non-legend items on basis of usual retail price, including any special sales price available to the general public. Claims processed and paid by State Department of Health and Welfare.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. Including repairs and replacements. No limitations. Prior authorization by State office required for items not listed in fee schedule. Invoice of laboratory costs of materials and appliances must be attached to billing form. Reimbursement on basis of Ophthalmic Fee Schedule (contains the allowances for professional services that can be recognized in addition to the laboratory cost of materials). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).
<b>b. Hearing Aids</b>	Provided. For categorically needy persons only. No other limitations. Prior authorization by State office required. Reimbursement on basis of retail charge. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).
<b>c. Dentures</b>	Provided. No limitations. Prior authorization by fiscal agent's dental consultant required for items not listed in schedule of basic dental services. Reimbursement on basis of usual and customary charges up to prevailing State level. Claims processed and paid by State Department of Health and Welfare.
<b>d. Other Prosthetic Devices</b>	Provided. For categorically needy persons only. Prosthetic devices installed within the body or to replace such devices; artificial limbs and eyes; braces; and orthopedic shoes if determined to be a medical care expense. As prescribed by physician. Prior authorization by district office required for items costing \$75 or less; by State office for items costing in excess of \$75. Reimbursement on basis of reasonable charge as evaluated and approved by fiscal agent. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).
<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices. No limitations. Prior authorization required for non-legend drugs, supplies, and devices. Basis of reimbursement variable, according to provider utilized. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. For categorically needy persons only. No other limitations. Prior authorization by State office required, except where services are received as Medicare benefits by persons age 65 or older. Reimbursement on basis of reasonable cost (as reimbursable to the facility under the Medicare program). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Prior authorization by or notification to State office required.
<b>19. Personal Care Services In Patient's Home</b>	Provided. For categorically needy persons only. On an intermittent, full-time, or part-time basis, as prescribed by physician. Consisting of services commonly associated with the personal care of a sick person. Prior authorization by district office required. Reimbursement on basis of rate negotiated by district office caseworker with provider of the service. Claims processed and paid by State Department of Health and Welfare.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. For categorically needy persons only. Consisting of any other diagnostic, screening, preventive, or rehabilitative service prescribed, ordered, or directed by a physician which is not elsewhere described in Section B of this publication. Prior authorization by State office required. Reimbursement on basis of usual and customary charges as evaluated and approved by fiscal agent. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).

**B. Medical and Remedial Care and Services (Continued)**

<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. In emergencies and under other prescribed conditions governing provision of ambulance service as a Medicare benefit. No other limitations. No requirement for prior authorization. Reimbursement on basis of usual and customary charges as evaluated and approved by fiscal agent. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Medical Service).
<b>b. Other</b>	Provided. Public transportation, private vehicle, or other appropriate means. Including cost of food and lodging enroute, and services of an attendant, if needed. No requirements for prior authorization for transportation expenses; approval of State office required for travel expenses other than transportation (allowed only in exceptional circumstances). Reimbursement of taxicab or other common carrier on basis of usual fare charged for same distance to all other customers; of private transportation at rate of 10¢ per mile. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization and Physician Service).

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in foster home or private institution for whom a public agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p>
<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.



**C. Eligibility for Medical Assistance (Continued)**

<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(7) All children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part.</p>
<b>b. FFP Claimed in Administrative Costs Only</b>	<p style="text-align: center;"><i>Optional</i></p> <p>None</p>
<b>4. Coverage of the Medically Needy</b>	Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Items C.3.a., above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD, and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs. (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.

**C. Eligibility for Medical Assistance (Continued)**

<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
a. For Categorically Needy Persons	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
b. For Medically Needy Persons	<p>(1) <i>Income</i></p> <p>Annual income which may be retained for basic maintenance needs: \$2088 for one person, \$3336 for family of 2, \$3696 for 3, \$4056 for 4, and \$360 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$20 a month for personal expenses. Additional income may be applied to maintenance needs of dependents up to \$2088 for one dependent, \$3336 for 2 dependents, and higher amounts for additional dependents (according to progression stated in previous paragraph).</p> <p>(2) <i>Resources</i></p> <p>Home may be retained regardless of value or equity.</p> <p>Real property owned but not used as a home may be retained only if value does not cause total resources to exceed the maximum of liquid reserves allowable for a family (see below).</p> <p>The following personal property is exempt regardless of value: Clothing, jewelry, household equipment and furnishings, and an automobile.</p> <p>Value of personal property used to produce income, such as livestock, stock in trade, tools, machinery, or similar equipment is exempt until actually sold.</p> <p>Personal property in the form of liquid assets, including the cash surrender value of life insurance, may be retained up to \$2500 for one person, \$4000 for 2 persons, plus \$100 for each additional person in the family. Excess equity in convertible assets must be reduced to the allowable limits.</p> <p>Resources in excess of these amounts render an individual ineligible for medical assistance under the program.</p>
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.
<b>7. Identification to Vendors of Persons Eligible</b>	Identification cards are issued through the district offices to all persons certified as eligible. Each member of a family has his own card. Identification numbering system shows differentiation between money payment, non-money payment, categorically needy, and medically needy recipients.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Bureau of Medical Services (medical assistance unit) has a physician (M.D.) as Chief who is directly responsible to the Director of the Division of Welfare Services. There is a full-time Assistant Chief (medical social work). The Bureau also has the part-time services of a pharmaceutical consultant and two dental consultants (one the Director of the Bureau of Dental Health and one available by contract with the New Hampshire Dental Services Corporation).
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the regular field staff of the State agency who are social workers assigned to specific areas of the State.



**D. Administration and Management (Continued)**

<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Advisory Committee. It is composed of 19 members, of whom two are appointed by the Governor, one by the Commissioner of Health and Welfare, and 16 by the Director of the Division of Welfare. In addition, there are two ex officio members (Director of the Bureau of Medical Services and Director of the Bureau of Maternal and Child Health). Authority for the Committee is administrative.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act. [State pays deductibles and coinsurance under Parts A and B of Medicare for all persons age 65 or older eligible for benefits under that program.]
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Health and Welfare processes and pays claims for dental services; claims from providers of skilled nursing home care and from providers of "personal care services in patient's home by person certified by physician as qualified," and claims for legend and non-legend drugs and medical supplies. All other claims are processed and paid by fiscal agents.
<b>b. Fiscal Agents</b>	The State agency has entered into a fiscal agent contract with New Hampshire-Vermont Hospitalization and Physician Service (Blue Cross-Blue Shield) for the processing and payment of claims received from providers of all services except those from providers of skilled nursing home services, dental services, from non-professional persons providing personal care services in the home, and from pharmacies.  The State agency has also entered into a contract with the Dental Service Corporation for the fee evaluation (but not payment) on claims received from providers of dental services.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for New Hampshire as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 59.18.
<b>2. State/Local Participation</b>	The non-Federal share of costs of medical services provided under the program are met through State and local funds (as required by State law) as follows: For services provided to OAA recipients, 75% State funds, 25% local funds; for services provided to APTD recipients, 65% State funds, 35% local funds; for all other money payment and non-money payment recipients, 100% State funds. State funds are used to meet 100% of the costs of program administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially for the Department of Health and Welfare. Unobligated balance may be carried over at the end of the first fiscal year, but reverts to the State treasury at the end of the biennium.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, the program must be curtailed or a supplemental appropriation be obtained from the State Legislature.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Institutions and Agencies

January 1, 1970

NEW JERSEY

**A. General Information**

<b>1. Legal Base</b>	Chapter 413, New Jersey Laws of 1968, approved January 15, 1969, (The New Jersey Medical Assistance and Health Services Act).
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1970. Original plan approved by the Federal agency on December 31, 1969.
<b>3. Administrative Responsibility</b>	The Department of Institutions and Agencies serves as the single State agency with responsibility for administering the program on a Statewide basis.
<b>4. Historical Background</b>	<p>Provisions for vendor payment of the costs of medical care through the public assistance categories, in effect since 1957, applied at first to only a small part of the medical services provided to recipients. In March 1962 they were extended to all health care services encompassed in State law and plan provisions for OAA, APTD, and AFDC. The AB program provided medical care through the money payment to the recipient until July 1963, when vendor payment provisions became effective.</p> <p>At that same date, the State began a Federal-State program of Medical Assistance for the Aged, i.e., for persons age 65 and over who were not recipients of public assistance but met certain prescribed conditions of financial and medical need. The law divided the services into "Primary Services" and "Related Services", requiring that a person have received hospital care, nursing home care, or home health care before he could be eligible for the "related services" of medical practitioners, dental care, pharmaceutical services, and other specified diagnostic or therapeutic care or service. These programs continued until the beginning of the title XIX program.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to categorically needy persons is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>[Similar services for persons of all ages are also provided (Item B.20).]</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. Unlimited, except for exclusion of elective cosmetic surgery and diet therapy for exogenous obesity. No requirements for prior authorization, but need for initial hospitalization must be certified to by attending physician, with recertification for extension beyond days allowed under AID program ("Approval by Individual Diagnosis" — a system whereby the initial number of days of hospitalization approved depends on the diagnosed condition for which the patient is treated). Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Hospital Service Plan of New Jersey or Prudential Insurance Company of America).
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by Department of Institutions and Agencies.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by Department of Institutions and Agencies.



**B. Medical and Remedial Care and Services (Continued)**

<b>2. Outpatient Hospital Services</b>	Provided. Including take-home drugs dispensed by hospital pharmacy. No limitations, except for exclusion of elective surgery. Payment is made to either the practitioner or to the facility, but not both, for services provided during same period of time for same condition(s). Certification and recertification of need is required for services which involve an extended course of treatment. Reimbursement on basis of reasonable cost limited to 100% of billed eligible charges. Claims processed and paid by fiscal agent (Hospital Service Plan of New Jersey <i>or</i> Prudential Insurance Company of America).
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization, but services must be recommended by attending practitioner. Reimbursement on basis of customary charge, not to exceed fixed fee schedule allowances. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No durational limitations. Prior authorization from local medical assistance office required except where patient is transferred to nursing home direct from an acute care facility. Reimbursement on basis of cost related fixed per diem rate established for each nursing home. Claims processed and paid by Department of Institutions and Agencies.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in the regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. Prior authorization by local office required for elective cosmetic surgery and for psychiatric treatment when costs exceed \$300 in given year. No additional payment for injections or drugs dispensed. Reimbursement on basis of customary charge, not to exceed fixed fee schedule allowance. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided, with the exception of routine foot care, subluxations of the foot, and treatment of flat foot conditions. Prior authorization by State office required for all treatments beyond initial examination and evaluation. Multiple visits to patients in same health facility or a congregate living arrangement reimbursed on an out-of-office visit basis for first patient seen, and on an office-visit basis for each additional covered person receiving services on the same occasion. No additional payment for injections or drugs dispensed by podiatrist. Reimbursement on basis of customary charges, not to exceed fixed fee schedule allowance. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).
<b>b. Optometrists</b>	Provided. Optometric examination, subnormal visual examination, optical appliances, and visual training. No limitations. Prior authorization by State office required for optometric examinations in excess of one a year for persons under age 16, or one every two years for persons over age 16; for purchase of optical appliances; for repairs to optical appliances costing over \$5; for visual training; and for other optometric treatment. Reimbursement on basis of fixed fee schedule. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided if furnished by home health agency to homebound patient (not including hospital or skilled nursing home as place of residence) pursuant to physician's order and in accordance with a plan of treatment. No limitation on number of visits. No requirements for prior authorization for such services when provided as Medicare benefits to persons age 65 or older; in all other cases, prior authorization by local office required for services beyond initial evaluation visit, and further authorization after 60 days with submission of progress report and recommendation for extension of treatment plan. Initial or subsequent authorizations may not exceed 60 calendar days. Reimbursement on basis of reasonable costs. Claims processed and paid by fiscal agent (Hospital Service Plan of New Jersey <i>or</i> Prudential Insurance Company of America).</p> <p>(b) Services of home health aide. Provided if furnished by home health agency to homebound patient (not including hospital or skilled nursing home as place of residence) pursuant to physician's order and in accordance with a plan of treatment and if the home health aide is under the supervision of a registered nurse on the staff of the Home Health Agency. No limitation on number of visits. No requirements for prior authorization for such services when provided as Medicare benefits to persons age 65 or older; in all other cases, prior authorization by local office required for initial service, and further authorization after 60 days with submission of progress report and recommendation for extension of treatment plan. Reimbursement on basis of reasonable costs. Claims processed and paid by fiscal agent (Hospital Service Plan of New Jersey <i>or</i> Prudential Insurance Company of America).</p> <p>(c) Medical supplies, equipment, and appliances. Provided, including purchase or rental of hospital beds, wheel chairs, and other durable medical equipment; bandages, surgical dressings, catheters, and other medical supplies. No requirements for prior authorization for such items when provided as Medicare benefits to persons age 65 or older; in all other cases, prior authorization by local office required for items costing over \$20. Reimbursement on basis of customary charge, not to exceed an allowance deemed reasonable by Commissioner. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. In facilities meeting minimum standards of New Jersey Department of Health to qualify as Independent Outpatient Health Facility. No limitations. Prior authorization by local office for services beyond initial examination and evaluation. Reimbursement on basis of customary charge, not to exceed a \$5 all-inclusive per diem rate, unless a cost related rate has been negotiated. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).</p>
<b>11. Dental Services</b>	<p>Provided. Except for fixed prosthodontia. Orthodontia and periodontal treatment provided on a selective basis. Prior authorization is required for all dental care except for examination with necessary radiography to a maximum of \$25.00, emergency treatment, and preventive dental care. Reimbursement on basis of customary and usual fee, subject to limitations based on criteria developed in consultation with the New Jersey State Dental Society, when these do not exceed Federal regulatory maximums and reasonable rates as determined by the State Department of Institutions and Agencies. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).</p>



**B. Medical and Remedial Care and Services (Continued)**

<p><b>12. Physical Therapy and Related Services</b></p> <p><b>a. Physical Therapy</b></p> <p><b>b. Occupational Therapy</b></p> <p><b>c. Speech Therapy</b></p> <p><b>d. Audiology</b></p>	<p>Provided. Limited to such services when provided to patient in own home or in a skilled nursing home by an approved home health agency, hospital outpatient department, or independent outpatient health clinic. No payments to privately practicing therapists. No other limitations. No requirement for prior authorization for such services when provided as Medicare benefits to persons age 65 or older; in all other cases, prior authorization by local office required for rehabilitation services rendered by a home health agency. Services rendered by a hospital outpatient department and an independent outpatient facility require certification and recertification of need to be submitted to local office for review. Reimbursement on basis established for the facility or agency rendering the service. Claims processed and paid by fiscal agent (Prudential Insurance Company of America <i>or</i> Hospital Service Plan of New Jersey).</p> <p>Provided. Limited to such services when provided to patient in own home or in a skilled nursing home by an approved home health agency, hospital outpatient department, or independent outpatient health clinic. No payments to privately practicing therapists. No other limitations. No requirement for prior authorization for such services when provided as Medicare benefits to persons age 65 or older; in all other cases, prior authorization by local office required for rehabilitation services rendered by a hospital outpatient department and an independent outpatient facility require certification and recertification of need to be submitted to local office for review. Reimbursement on basis established for the facility or agency rendering the service. Claims processed and paid by fiscal agent (Prudential Insurance Company of America <i>or</i> Hospital Service Plan of New Jersey).</p> <p>Provided. Limited to such services when provided to patient in own home or in a skilled nursing home by an approved home health agency, hospital outpatient department, or independent outpatient health clinic. No payments to privately practicing therapists. No other limitations. No requirement for prior authorization for such services when provided as Medicare benefits to persons age 65 or older; in all other cases, prior authorization by local office required for rehabilitation services rendered by a home health agency. Services rendered by a hospital outpatient department and an independent outpatient facility require certification and recertification of need to be submitted to local office for review. Reimbursement on basis established for the facility or agency rendering the service. Claims processed and paid by fiscal agent (Prudential Insurance Company of America <i>or</i> Hospital Service Plan of New Jersey).</p> <p>Provided. Limited to such services when provided as part of clinic or hospital outpatient services. No payment to privately practicing audiologists. Prior authorization by local office required. Reimbursement on basis established for the facility or agency rendering the service. Claims processed and paid by fiscal agent (Prudential Insurance Company of America <i>or</i> Hospital Service Plan of New Jersey).</p>
<p><b>13. Prescribed Drugs</b></p>	<p>Provided. Including legend and non-legend drugs. Limit of 60-day supply per prescription, with not more than 2 refills in a 6-month period; except oral contraceptives, for which a 3-month supply may be prescribed initially, with 2 refills in a 9-month period. Prior authorization by local office required for: injectables (except insulin, and all injectable medication when prescribed for and provided to a patient in a long-term care facility, i.e., skilled nursing home, infirmary section of Homes for the Aged, or Public Medical Institution); vitamins for persons age 6 to 65, antiobesics, and anorexics; also for prescription for more than a 10-day supply of oral antibiotics and anti-infective agents. Payments made to licensed pharmacies which have executed a participation agreement with the State agency. No payments to practitioners for injections or dispensed drugs. Reimbursement for legend drugs on basis of invoice cost plus a dispensing fee of \$1.85; for non-legend drugs on basis of usual retail price charged to general public. No extra charge allowed for repackaging. Claims processed and paid by fiscal agent (Hospital Service Plan of New Jersey).</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided, within the following limitations: (1) Prescription sunglasses not provided, (2) Kryptok bifocals only when prescribed, (3) tinted lenses only when medically indicated, and (4) contact lenses only for specific ocular pathological conditions or for patients who cannot be fitted with regular lenses. Prior authorization from State office required for all services except necessary optometric examinations. Reimbursement for eyeglasses and frames on basis of wholesale cost plus dispensing fee (\$5 maximum allowable wholesale cost for frames); for services, on basis of reasonable charge, not to exceed an allowance deemed reasonable by State office. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).
<b>b. Hearing Aids</b>	Provided. Including payment for hearing aid batteries. Audiometric evaluation required. No other limitations. Prior authorization by local office required for any equipment costing more than \$20. Reimbursement on basis of customary charge, not to exceed an allowance deemed reasonable by State office. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).
<b>c. Dentures</b>	Provided. Partial or complete dentures are provided only when masticatory deficiencies are likely to impair general health of the patient. Prior authorization by local office required for all services except (1) examination with required radiography, and (2) emergency treatment. Reimbursement on basis of customary and usual fee, subject to limitations based on criteria developed in consultation with the New Jersey State Dental Society, when these do not exceed Federal regulatory maximums and reasonable rates as determined by the State Department of Institutions and Agencies. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).
<b>d. Other Prosthetic Devices</b>	Provided. Including devices to replace all or part of an internal organ; artificial limbs, braces, abdominal and other supports, orthopedic shoes. No limitations except that orthopedic shoes are provided only when attached to braces or are high-top. Prior authorization by central office required for limbs, braces, supports, and for shoes when cost exceeds \$20. Reimbursement on basis of customary charge not to exceed a fee schedule deemed reasonable by the State agency. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).
<b>15. Family Planning Services</b>	Provided. No limitations. No requirements for prior authorization. Basis of reimbursement varies according to type of vendor. Claims processed and paid by fiscal agent (Prudential Insurance Company of America).
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. No limitations. Reimbursement on basis of negotiated rate. Claims processed and paid by fiscal agent (Prudential Insurance Company of America <i>or</i> Hospital Service Plan of New Jersey).
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Limited to emergency services with a maximum of 20 days payment allowed. No requirements for prior authorization. Reimbursement limited to 80% of reasonable covered charges. Claims processed and paid by fiscal agent (Hospital Service Plan of New Jersey).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. All medically needed services covered wherever provided, including routine physical examinations and diagnostic examinations. No limitations. Prior authorization by local office required when services are provided in nursing homes and for prosthetic appliances. Basis of reimbursement varies according to type of vendor providing the service. Claims processed and paid by fiscal agent (Prudential Insurance Company of America <i>or</i> Hospital Service Plan of New Jersey); except claims received from nursing homes, which are processed and paid by Department of Institutions and Agencies.





**C. Eligibility for Medical Assistance (Continued)**

3. Coverage of the Categorically Needy	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
a. FFP Claimed in Medical and Administrative Costs	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) All children under age 21 in foster homes or private institutions for whom the Bureau of Children's Services is assuming financial responsibility in whole or in part.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only.)</p>
	<p style="text-align: center;"><i>Optional</i></p> <p>Pending resolution of Title IV compliance issue involving exemption of earned income in AFDC, Title XIX coverage is provided to certain families determined by the State to be ineligible for money payments on the basis of income of the parents.</p>
b. FFP Claimed in Administrative Costs Only	
4. Coverage of the Medically Needy	Not included.
5. Financial Criteria	The following criteria are used in establishing financial eligibility for medical assistance:
a. For Categorically Needy Persons	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
b. For Medically Needy Persons	Not applicable.
6. Financial Responsibility of Relatives	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parent for children who are under age 21 or blind or permanently and totally disabled.
7. Identification to Vendors of Persons Eligible	Each case receives a monthly validation form which identifies current eligibility and all eligible persons included under the case name. In addition to case name and case number, each person is listed by first name, age, and person number. A plastic card bearing the case name and case number is issued also by the State agency to each single-person case or to each multiple-person case certified as eligible for medical assistance. This plastic card serves both as a means of identification and as a device for stamping an identification imprint on claim forms.



**D. Administration and Management**

1. Medical Assistance Unit	The Division of Medical Assistance and Health Services (the medical assistance unit) is headed by a director who is directly responsible to the agency Commissioner. The professional medical staff includes 6 physician specialists (one of whom is a psychiatrist), 2 dentists, 1 pharmacist, 1 optometrist, 2 podiatrists, 1 optician; 4 medical social workers (MSW); and a Medical Care Administrator; a Health Education Consultant (RN), Chief Nurse - Long Term Care (RN), Supervisor - Child Health (RN); and 2 program assistants with public health or health administration backgrounds. In addition, there is a Chief of Claims and Accounts, Chief of Health Statistics and Economics, Chief of Local Administration, Data Processing Analyst, Health Economics Consultant, and appropriate supporting staff.
2. Supervision of Statewide Operations	Supervision of the medical aspects of Statewide operations is accomplished through a full-time staff of 5 Regional Medical Care administrators, 18 Local Medical administrators, 8 Regional Nurse Supervisors, and 33 Regional Staff Nurses. There are also part-time consultants: 34 local dentists, 20 local pharmacists, and 49 local physicians. These staff members work in 18 local medical units (21 counties) organized under 5 regional offices. The eligibility determination aspects of the program are carried out by the county welfare departments under the supervision of the regular field staff of the State agency.
3. Advisory Council	The State advisory body for title XIX is known as the Medical Assistance Advisory Council. It is composed of 29 members appointed by the Board of Control. There are 5 ex officio members, without vote. (Director, Division of Public Welfare; Director, Division of Aging; Chairman, Board of Public Welfare; Commissioner, Department of Health; Acting Director, New Jersey Rehabilitation Commission.) Authority for the Council is administrative (resolution of the Board of Control).
4. Buy-In Agreement	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
5. Claims Payment Process	<div data-bbox="132 1081 335 1144">a. State and Local Agencies</div> <div data-bbox="483 1081 1527 1165">Division of Medical Assistance and Health Services processes and makes payment of claims for services of skilled nursing homes and eligible State and county hospitals for mental diseases and for tuberculosis.</div> <div data-bbox="132 1197 311 1228">b. Fiscal Agents</div> <div data-bbox="483 1197 1527 1585"> <p>Contracts have been negotiated on behalf of the State of New Jersey with two companies to function as its contractors for specified kinds of medical services.</p> <p>(1) <i>Hospital Service Plan of New Jersey</i> processes and pays claims from (a) providers of hospital inpatient, hospital outpatient, and home health agencies services who have selected this plan as their intermediary under Title XVIII; (b) claims from all providers of pharmaceutical services; (c) claims for out-of-State hospitals and home health agencies; and (d) claims from hospitals who have not participated in Title XVIII.</p> <p>(2) <i>Prudential Insurance Company of America</i> processes and pays claims from (a) providers of hospital inpatient, hospital outpatient, and home health agency services who have selected Prudential as their intermediary under Title XVIII; and (b) claims for all other health services covered by the program and not identified in sub-item a. above or b.(1) above.</p> </div> <div data-bbox="132 1606 319 1690">c. Prepaid Capitation Arrangements</div> <div data-bbox="483 1606 845 1638">Provided. None completed as yet.</div> <div data-bbox="132 1722 303 1806">d. Payments to Non-Medical Institutions</div> <div data-bbox="483 1722 550 1753">None.</div>

**E. Financing**

1. Federal Financial Participation	The Federal Medical Assistance percentage for New Jersey as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.00.
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**E. Financing (Continued)**

<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually. Balance may not be carried over;reverts to the General Fund at the end of each fiscal year.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, a request to the State Legislature for a deficiency appropriation is initiated by the Commissioner of the Department of Institutions and Agencies.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Health and Social Services Department

January 1, 1970

NEW MEXICO

**A. General Information**

<b>1. Legal Base</b>	Section 13-1-1 et seq., New Mexico Statutes annotated, 1953 Compilation.
<b>2. Beginning Dates</b>	Program went into operation on December 1, 1966. Original plan approved by the Federal agency on November 16, 1966.
<b>3. Administrative Responsibility</b>	The New Mexico Health and Social Services Department serves as the single State agency with responsibility for administering the program on a Statewide basis.
<b>4. Historical Background</b>	<p>Vendor payments to the providers of medical care for recipients of aid under the Federal-State public assistance programs have been in effect in New Mexico since July 1951. The State was one of the first to implement the 1950 amendment to the Federal Social Security Act authorizing Federal financial participation in such payments. By 1952 the State had set up a "pooled fund" into which per capita premiums for each recipient were deposited each month and from which claims from providers of medical care were paid. This method of handling payments continued until 1966 when the title XIX program began.</p> <p>In 1963, when the State moved to the two-category system of public assistance (Aid to the Aged, Blind, or Disabled and Aid to Families with Dependent Children), a specific amendment authorized the Federal-State program of Medical Assistance for the Aged (MAA), for persons age 65 and older who were not recipients of public assistance but met certain criteria of financial and medical need. In the next biennial session of the Legislature, an appropriation was made and the program became operative in July, 1965. The services provided were inpatient hospital care (limited to treatment of life-endangering conditions, diagnosis and treatment that cannot be obtained outside a hospital, and relief of pain and suffering or care of a traumatic condition) and prescribed medications or medical supplies "in excess of \$10 a month 'per drug store'." This program was discontinued June 30, 1966, in anticipation of the beginning of the title XIX program.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exception:</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Item B.8.(b).)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	<p>Provided. Including private room accommodations on written statement of attending physician as to medical necessity. Organ transplants limited to kidneys and cornea. No other limitations. Written approval by State agency required prior to hospitalization for cosmetic or elective surgery. No other requirements for prior authorization, but claim for stay beyond 7 days must be supported by written justification of attending physician, and claim for stay beyond 14 days is subject to approval by State agency prior to payment. No further payment for inpatient services after determination by attending physician or Utilization Review Committee that hospitalization is no longer required, unless skilled nursing care is required and a determination made by county welfare office that a skilled nursing home bed is unavailable. Reimbursement on basis of reasonable cost (Title XVIII principles and standards applied). Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).</p>
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>2. Outpatient Hospital Services</b>	Provided. Including use of minor surgery or cast room, use of emergency room for treatment of medical emergencies, catheter change, administration of intravenous infusions or transfusions, first aid care of injuries, medications and medical supplies, and visits to an organized hospital outpatient department clinic (limited to Bernalillo County Medical Center Out-Patient Department, Albuquerque). No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charges (Title XVIII principles and standards applied). Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Claims processed and paid by fiscal agent (Hospital Plan, Inc. and Surgical Service, Inc.)
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. Attending physician's certification and periodic recertification (before 14th day of confinement and for each subsequent 30 days of care) required. No requirements for prior authorization, but approval by State agency required prior to payment, based on medical and social data accompanying request for payment. Reimbursement on basis of institution's certified audit report of costs (no retroactive adjustment); payment not to exceed \$15 maximum per diem rate established by State agency. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. Unlimited services for persons age 65 or older covered by State's buy-in agreement when received as Medicare benefits. For others, visits (non-surgical) to hospital inpatients limited to one per day; no payment for visits during non-approved period of hospitalization for elective and cosmetic surgery. Unlimited outpatient services in office, patient's home, or elsewhere, except for exclusion of (1) office visits, the need for which is not medically indicated by patient's condition, and (2) office visits not involving a direct patient-physician relationship (e.g., solely for purpose of prescription renewal or receiving medication, therapy, or advice from a para-medical person). Prior approval by State agency required for elective and cosmetic outpatient and inpatient surgery. No other limitations or requirements for prior authorization. Reimbursement on basis of fixed fee schedule. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. No limitations. Prior authorization by State office required for certain surgical procedures. Reimbursement on basis of schedule of maximum allowances, not to exceed customary charges of practitioner. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>b. Optometrists</b>	Provided. Routine optometric services, including vision analysis, case work-up, consultation, and vision screening. No limitations. No requirements for prior authorization. Reimbursement on basis of relative value scale with individual conversion factors. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).



**B. Medical and Remedial Care and Services (Continued)**

<b>c. Chiropractors</b>	Provided. Limited to office visits and routine diagnostic X-rays. No other limitations if need for visit is medically indicated by patient's condition and involves a direct patient-practitioner relationship. No requirements for prior authorization. Reimbursement on basis of \$3 per visit. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>d. Other</b>	<p>(1) Services of registered nurse midwives. Provided. Including prenatal care and delivery of mother, and postnatal care of mother and infant. Limited to services rendered by Catholic Maternity Institute (now known as Community Maternity Institute) Santa Fe. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).</p> <p>(2) Services of certified psychologists. Provided. Consisting of examinations and therapy. No limitations. Prior written approval by State office required. Reimbursement for examination at rate of \$10 to \$30 depending on type of test administered; of therapy on basis of fee negotiated by State in consultation with provider. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).</p>
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided. As furnished by certified home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of fees individually negotiated with each agency. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).</p> <p>(b) Services of home health aide. Provided. Limited to persons age 65 or older covered by State's buy-in agreement and to such services received as Medicare benefits. No other limitations. No requirements for prior authorization. Reimbursement on basis of fees individually negotiated with each agency. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).</p> <p>(c) Medical supplies, equipment, and appliances. When needed by non-institutionalized patient for on-going course of treatment. Including medical supply items; rental (for period not to exceed 6 months) or purchase of durable equipment; trusses, elastic stockings, and anatomical supports. No requirements for prior authorization when received as Medicare benefits by persons age 65 or older covered by State's buy-in agreement. For others, approval of State office required for purchase of durable equipment and for custom-made or custom-fitted anatomical supports. Reimbursement on basis of charges which are usual and customary, according to established rates of the payment practices of the California Relative Value Studies, Section IV. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Provided. Limited to services provided in a hospital, when Intensive Care Nursing Services are not available. Prior approval by State agency required. Reimbursement on basis of local prevailing rate determined by State nurses' associations. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>10. Clinic Services (Other than Hospital)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of negotiated fee schedule (equivalent to usual, customary, and reasonable charges). Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>11. Dental Services</b>	Provided. Orthodontia limited to children and adolescents. No other limitations. Written approval by State office required for dentures, crowns, castings, orthodontia, and all other services except examinations, consultations, and routine dental care. Reimbursement on basis of fee schedule (based on usual, customary, and reasonable charges subject to the 75th percentile limitation). Claims processed and paid by fiscal agent (Hospital Plan Inc., and Surgical Service, Inc.).

**B. Medical and Remedial Care and Services (Continued)**

<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. No limitations. Prior approval from HSSD Medical Consultant required. Reimbursement to home health agencies on audited cost basis; of other providers on basis of fee schedule. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>b. Occupational Therapy</b>	Provided. As furnished by home health agency or other qualified provider acceptable to prescribing physician. No limitations. Prior approval from HSSD Medical Consultant required. Reimbursement to home health agency on audited cost basis; of other providers on basis of fee schedule. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>c. Speech Therapy</b>	Provided. As furnished by home health agency or other qualified provider acceptable to prescribing physician. No limitations. Prior approval from State Office required. Reimbursement to home health agency on audited cost basis; of other providers on basis of fee schedule. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>d. Audiology</b>	Provided. No limitations. Prior approval from State Office required. Reimbursement on basis of fee schedule. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>13. Prescribed Drugs</b>	Provided. Legend drugs and insulin. As prescribed by physician or dentist. Medications for tuberculosis excluded. Not less than 30-day supply per prescription for maintenance drugs. Certain non-legend items provided on an exception basis (e.g., salicylates for arthritis; formulas for infants under 6 months of age), upon approval by State office of physician's written request. No other requirements for prior approval. Reimbursement on basis of pharmacist's usual and customary charge, not to exceed local wholesale cost of ingredients plus \$2 dispensing fee. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. Artificial eyes, eyeglasses, lenses, contact lenses, and frames. Includes repair and replacement of glasses and lenses. No limitations. Prior approval by State office required. Reimbursement on basis of invoice cost plus fee for professional component. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>b. Hearing Aids</b>	Provided. Including supplies, repairs, and replacements. No limitations. Prior approval by State office required. Reimbursement on basis of charges. (Providers usually offer a discount.) Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>c. Dentures</b>	Provided. No limitations. Prior approval by State office required. Reimbursement on basis of fee schedule. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>d. Other Prosthetic Devices</b>	Provided. Including devices to replace all or part of an internal organ; artificial limbs, braces, and supports; orthopedic shoes, shoe lifts, and shoe inserts. No limitations. Prior approval by State office required for all items except devices implanted internally. Reimbursement on basis of charge. (Providers usually offer a discount.) Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>15. Family Planning Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on variable basis according to provider utilized. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. For period necessary until patient can safely be moved elsewhere without danger to life or impairment of health. Reimbursement on basis of reasonable cost (title XVIII principles and standards). Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. When patient's condition precludes other means of transportation. No limitations. No requirements for prior authorization. Reimbursement on basis of customary and reasonable charges for the locality; payment not to exceed tariff charges for ambulances as set by State tariff regulatory agency. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).
<b>b. Other</b>	<p>Provided. By public carrier (e.g., bus, train, or airplane) when required to secure medical services not available in home community or environs within a 50-mile radius; also meals and lodgings enroute for patient and necessary attendant, if needed to secure medical services away from patient's home community and when arrangements with a room-and-board facility have been made in advance by county office. Prior authorization by State office required. Reimbursement of public carrier on basis of rates set by State tariff regulatory agency; of room-and-board facility on basis of \$6.60 per 24 hours. Claims processed and paid by fiscal agent (Hospital Plan, Inc., and Surgical Service, Inc.).</p> <p>[Additional transportation and travel expenses may be provided without Federal financial participation by county office disbursements from petty cash fund for transportation by private carrier at rate of 3¢ per mile each way, and for per diem maintenance for patient and necessary attendant at rate of \$2 for each 6 hours away from home. Petty cash fund consists of monies allocated to county by State agency.]</p>

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in foster home or private institution for whom a public agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p>

**C. Eligibility for Medical Assistance (Continued)**

b. Age 21 to 64	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
c. Age 65 or older	(1) Individual who has attained age 65.
<b>3. Coverage of the Categorically Needy</b>  a. FFP Claimed in Medical and Administrative Costs	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of AABD and AFDC.</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving AABD or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) All children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part.</p> <p style="text-align: center;"><i>Optional</i></p> <p>b. FFP Claimed in Administrative Costs Only</p> <p>None.</p>
4. Coverage of the Medically Needy	Not included.
<b>5. Financial Criteria</b>  a. For Categorically Needy Persons  b. For Medically Needy Persons	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>Not applicable.</p>
6. Financial Responsibility of Relatives	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.
7. Identification to Vendors of Persons Eligible	A Medical Identification Card is issued monthly to the payee of each budget group in the form of a tear-off stub attached to the financial assistance check. (For non-money payment cases, the check portion is blank.) Card shows case number and county as well as the individual name and identification number of each eligible family member. Card certifies to medical eligibility only for the month issued, except that the identification card for children in foster care (home or private institution), issued on a one-time basis by the county office, is valid until recalled.



**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Chief, Medical Assistance Section, is a Medical Social Worker who is responsible directly to the Director of the Assistance Administration Division. The full-time professional staff of the Section consists of: a Medical Social Consultant (medical social work), a Drug Program Administrator (pharmacy), and a Medical Consultant (M.D.). These are assisted by the following part-time staff: Dental Consultant, Medical Consultant (M.D.), Consulting Ophthalmologist, Consulting Optometrist, and Podiatry Consultant.
<b>2. Supervision of Statewide Operations</b>	Supervision of the medical aspects of Statewide operations is accomplished through the consultative and supervisory staff of the Medical Assistance Section identified above in Item D.1., working out of the State office. Supervision of the eligibility and other public assistance aspects of the program is accomplished through the regular field staff of the Assistance Administration Division.
<b>3. Advisory Council</b>	The State Advisory body for title XIX is known as the Medical Advisory Committee. It is composed of 8 members appointed by the Executive Director of the Health and Social Services Department. There are 3 ex officio members (Executive Director of the Health and Social Services Department, Chief of the Medical Assistance Division, and Medical Consultant for title XIX). Authority for the Committee is administrative.
<b>4. Buy-in Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Health and Social Services Department is not directly involved in the processing and payment of claims from providers but carries this responsibility through a contract with a fiscal agent.
<b>b. Fiscal Agents</b>	The State agency has entered into a joint contract with Hospital Plan, Inc., and Surgical Service, Inc. (the Blue Cross-Blue Shield organizations) as fiscal agent to process and pay all claims from providers of medical care and services.
<b>c. Prepaid Capitation Arrangements</b>	None
<b>d. Payments to Non-Medical Institutions</b>	None

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for New Mexico, as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 71.48.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually. Unobligated balance may not be carried over at the end of a fiscal year.
<b>4. Deficit Financing</b>	State Constitution prohibits deficit spending. If additional funds are needed before the next appropriation period, the program must be curtailed or an additional appropriation be obtained from the State Legislature.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Social Services

January 1, 1970

NEW YORK

**A. General Information**

<b>1. Legal Base</b>	New York Social Services Law, Article 5, Title 11 (Medical Assistance for Needy Persons), as amended. Title 11 was added by Chapters 256 and 257, Laws 1966, Regular Session, which provided the original authorization for a State program under title XIX of the Social Security Act.
<b>2. Beginning Dates</b>	Program went into operation on May 1, 1966. Original plan approved by the Federal agency on November 15, 1966.
<b>3. Administrative Responsibility</b>	<p>The State Department of Social Services serves as the single State agency with over-all responsibility for the Medical Assistance Program. Under supervision of the single State agency, the New York program is locally administered by 64 county and city departments of social services. Pursuant to a requirement in State law that certain administrative and supervisory functions be performed by the State Department of Health, a cooperative agreement was entered into between the State Department of Social Services and the State Department of Health, effective October 31, 1966. Under this agreement, the State Department of Health is made responsible for administration and supervision of the medical care and health services available under Medical Assistance either directly through the employment of medical directors for this purpose or through contracts with local health districts; for development of standards of medical care (set forth in State Medical Manual) governing content of local medical plans; for requiring adherence of providers to standards; for review and certification of local medical plans for subsequent approval by the State Department of Social Services; and for the periodic review and audit of the quality and availability of services provided.</p> <p>EXCEPTION: Program is State (rather than locally) administered with respect to certain eligible patients in institutions for the mentally ill and the mentally retarded which are operated by the State Department of Mental Hygiene. For this segment of the program, the State Department of Social Services has, by written agreement, delegated to the State Department of Mental Hygiene responsibility for the provision of medical care and related matters. Other aspects of this segment of the program, including determination of eligibility, are administered by the State Department of Social Services either through activities of its own staff or by the local social services departments under its supervision.</p>
<b>4. Historical Background</b>	Since May 1951 the State had received Federal financial participation in the cost of providing a comprehensive range of medical and remedial care and services for public assistance recipients in all categories. Operating under a county-administered, State-supervised system each local welfare agency was required to develop a plan for Federal-State aided services to recipients based on the State Manual and subject to approval by the Department of Social Welfare. Decision was made by the local agency as to whether a particular medical service would be provided through vendor payment to the provider or by the inclusion of a dollar amount in the recipient's money payment. On April 1, 1961, on the basis of newly enacted legislation, a Federal-State program of Medical Assistance for the Aged (MAA) was instituted providing comprehensive medical care for persons age 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need. As in the public assistance programs, an MAA plan was developed by each local agency and submitted to the State Department for approval. These programs continued until the beginning of the title XIX program.
<b>5. Scope of Coverage</b>	Program provides for coverage of both categorically needy and medically needy persons. (See Items C.3. and C.4., below.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exception:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c; B.4.b. and c.)</p>



**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by local Social Services district.</p> <p>Provided. Limited to persons age 65 or older who are patients in public hospitals. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by local Social Services district.</p> <p>Provided. Limited to persons age 65 or older who are patients in State hospitals operated by State Department of Mental Hygiene. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Reimbursement for such services is handled through direct appropriation by the New York State Legislature to the State Department of Mental Hygiene. (Limited waiver of the single State agency concept granted by Secretary of the U.S. Department of Health, Education, and Welfare, pursuant to Title II, Section 204, of the Intergovernmental Cooperation Act of 1968.)</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by local Social Services district.</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. No limitations except services must be recommended by physician, dentist, or other qualified practitioner. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For persons of all ages. No limitations. Prior authorization by local agency required when admission is not direct from hospital, and for extension of care beyond first 100 days in a spell of illness. Reimbursement on basis of reasonable cost, i.e., at rates individually determined for each facility and certified by the Commissioner of Health as reasonably related to the cost of providing care. Claims processed and paid by local Social Services district.</p> <p>Provided. Limited to persons age 65 or older who are patients in public hospitals. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by local Social Services district.</p> <p>Provided. Limited to persons age 65 or older who are patients in hospitals operated by State Department of Mental Hygiene. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Reimbursement for such services is handled through direct appropriation by the New York State Legislature to the State Department of Mental Hygiene. (Limited waiver of the single State agency concept granted by Secretary of the U.S. Department of Health, Education, and Welfare, pursuant to Title II, Section 204, of the Intergovernmental Cooperation Act of 1968.)</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Not provided.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedules with differential fees for specialists. Claims processed and paid by local Social Services district.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>	<p>Provided. No limitations. Prior authorization required for certain specified services. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Optometrists</b>	Provided. No limitations. No requirements for prior authorization except for specified types of eyeglasses. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.
<b>c. Chiropractors</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. No limitations. No requirements for prior authorization. Reimbursement to home health agency on basis of reasonable cost; of independent RN or LPN (only if service not available through home health agency) on basis of local prevailing rates in effect March 31, 1969. Claims processed and paid by local Social Services district.</p> <p>(b) Services of home health aide. Provided if furnished by home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by local Social Services district.</p> <p>(c) Medical supplies, equipment, and appliances. Provided, if ordered or recommended by physician. No limitations. Prior authorization required for (1) medical supplies and equipment costing in excess of \$40; (2) appliances (other than hearing aids) costing more than \$40 except when prescribed by a qualified orthopedic physician, surgeon, or physiatrist; (3) hearing aids for persons age 21 or over, except when written prescription obtained from an approved speech and hearing center. Reimbursement for medical supplies and equipment on basis of wholesale cost plus 40%; for appliances (other than hearing aids) on basis of local prevailing rates or agreements in effect March 31, 1969; for hearing aids on basis of an approved price list. Claims processed and paid by local Social Services district.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Provided. In hospital and patient's home. Not provided in skilled nursing home. No other limitations. Prior authorization required for services to patient in own home. Reimbursement on basis of local prevailing rates in effect as of 3/31/69. Claims processed and paid by local Social Services district.
<b>10. Clinic Services (Other than Hospital)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by local Social Services district.
<b>11. Dental Services</b>	Provided. Includes preventive, prophylactic and other routine dental care, services, and supplies deemed essential; prosthetic devices only if required to alleviate a serious health condition (including one which affects employability). Prior authorization is required for all prosthetic devices and for orthodontic care. Orthodontic care provided for young adults when supported by a written report from a qualified psychiatrist and approval of the dental director of an approved orthopedic screening center. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. Written order of physician required. No limitations. Prior authorization required for services of private-practicing therapist; initial and subsequent authorizations for such therapist's services may not exceed 3 months. No other limitations. No other requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.



**B. Medical and Remedial Care and Services (Continued)**

<b>b. Occupational Therapy</b>	Provided. Written order of physician required. No limitations. Prior authorization required for services of private-practicing therapist; initial and subsequent authorizations for such therapist's services may not exceed 3 months. No other limitations. No other requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.
<b>c. Speech Therapy</b>	Provided. Written order of physician required. No limitations. Prior authorization required for services of private-practicing therapist; initial and subsequent authorizations for such therapist's services may not exceed 3 months. No other limitations. No other requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.
<b>d. Audiology</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs, on written prescription of physician, dentist, or podiatrist. No limitations. Drugs costing in excess of \$40 require prior authorization. Reimbursement on basis of wholesale cost plus \$1.80 dispensing fee for compounded prescriptions, legend drugs, and non-legend drugs prescribed with specific directions different from those on original container or prescribed in quantity other than in unit or package size. All other non-legend drugs on basis of wholesale cost plus usual mark-up less 20% of such mark-up. Claims processed and paid by local Social Services district.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. On order of ophthalmologist or optometrist. No limitations. Prior authorization required for certain types of lenses. Payments to ophthalmologists, optometrists, and opticians. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.
<b>b. Hearing Aids</b>	Provided. No limitations. For children under 21, request must be supported by a written prescription from an approved speech and hearing center. Prior authorization required for persons over 21 except when written prescription is provided by approved speech and hearing center. Reimbursement on basis of an approved price list. Claims processed and paid by local Social Services district.
<b>c. Dentures</b>	Provided. Only to alleviate a serious health condition including one which affects employability. Prior authorization required. Reimbursement on basis of fee schedule. Claims processed and paid by local Social Services district.
<b>d. Other Prosthetic Devices</b>	Provided. Prosthetic devices and appliances which replace all or part of an internal organ, including replacement of device; artificial limbs and eyes, including replacement; braces, supports, and special shoes. No limitations. Prior authorization required when appliance costing in excess of \$40 is ordered by a non-specialist (i.e., not a qualified orthopedic physician, surgeon, or physiatrist). Reimbursement on basis of local prevailing rates or agreements in effect March 31, 1969. Claims processed and paid by local Social Services district.
<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices. No limitations. No requirements for prior authorization. Reimbursement on basis of applicable fee schedules (i.e., schedules for physicians, clinics, drugs, and sickroom supplies.) Claims processed and paid by local Social Services district.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Limited to situations where threat of death or serious impairment of health necessitates use of most accessible hospital available. Prior authorization not required. Reimbursement on basis of reasonable costs. Claims processed and paid by local Social Services district.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. When properly prescribed or recommended.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. No limitations. Prior authorization required except in an emergency. Reimbursement on basis of local prevailing rates as of March 31, 1969. Claims processed and paid by local Social Services district.
<b>b. Other</b>	Provided. Transportation by invalid coach, taxicab, common carrier, or other appropriate means. Prior authorization required except in an emergency. Reimbursement of invalid coaches on basis of local prevailing rates as of March 31, 1969. Common carriers (i.e. taxi, bus, plane, train, etc.) are reimbursed on the basis of rates established by the proper local or other authority. Claims processed and paid by local Social Services district.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the third month preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	(1) Individual under age 21.
<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(4) Essential spouse [title XIX definition] of a recipient of AABD.</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.



### C. Eligibility for Medical Assistance (Continued)

<b>3. Coverage of the Categorically Needy</b>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p>
<p><b>a. FFP Claimed in Medical and Administrative Costs</b></p>	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of AABD and AFDC.</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving AABD or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(7) All individuals under age 21.</p> <p>(8) Essential spouse [title XIX definition] of a recipient of AABD. (Categorically needy only)</p>
<p><b>b. FFP Claimed in Administrative Costs Only</b></p>	<p style="text-align: center;"><i>Optional</i></p> <p>(1) Adult recipients of money payments under the State's General Assistance program.</p> <p>(2) All adult persons eligible for but not receiving money payments under the State's General Assistance program.</p> <p>(3) Persons not otherwise eligible for medical assistance who meet the catastrophic illness provisions of the State statute.</p>
<p><b>4. Coverage of the Medically Needy</b></p>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Items C.3.a.(1) through (7), and Item C.3.b., above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess, in accordance with regulations.</p> <p>[NOTE: A statute enacted in 1969 (Ch. 1118, Laws of 1969) requires a medically needy person to share in the cost of outpatient services by paying 20% of his bill for services "other than in-patient care and services in a medical institution". Although enacted to be effective July 1, 1969, the law was not implemented in the title XIX plan as of January 1, 1970.]</p>
<p><b>5. Financial Criteria</b></p> <p><b>a. For Categorically Needy Persons</b></p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p><b>(1) <i>Income</i></b></p> <p>Annual income which may be retained for basic maintenance needs: \$2200 for one person, \$3100 for family of 2, \$4000 for 3, \$5000 for 4, \$5700 for 5, \$6400 for 6, \$7200 for 7, and \$600 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$15 a month for personal expenses. Additional income may be applied to maintenance needs of dependents up to \$2200 for one dependent, \$3100 for 2 dependents, and higher amounts for additional dependents (according to progression stated in preceding paragraph).</p> <p>Excluded for consideration as income (or as resources) are: Contributions up to \$1080 annually from a person who resides in but is not a member of the family household.</p> <p><b>(2) <i>Resources</i></b></p> <p>Homestead may be retained regardless of value of equity. ("Homestead" defined as home and land "owned and occupied", together with such appurtenant structures as out-buildings and garages. Term includes home trailers and mobile homes; homes consisting of one, two, or three apartments; and homes consisting of one or two apartments and one store or office.)</p> <p>Income-producing real property (not used as a homestead) may be retained regardless of value; profit derived considered as part of available annual income; mortgage must be negotiated, if possible, and proceeds included in consideration of available resources. Non-income-producing real property (not used as a homestead) is not exempt; value considered available to meet medical expenses.</p> <p>The following personal property is exempt, regardless of value: Clothing, personal effects, furniture, appliances, equipment, an automobile, and tools and equipment necessary for a trade, occupation or business.</p> <p>A "burial reserve" of \$500 is allowed for each member of the family household but not in excess of \$2000 per family. Additional savings are exempt up to one-half of annual net income exemption (see Item C.5.b.(1)). Cash value of life insurance policies is included in determining burial reserve and savings exemption. Term, group, and other insurance having no loan value not considered an asset.</p> <p>Resources in excess of these amounts do not render an individual ineligible, but excess must be applied to costs of medical care.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children under age 21.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>A Medical Identification Card is issued to all persons certified by the local county and city departments of social services as eligible. Cards for families in receipt of cash assistance are issued monthly; in other cases, the cards are issued for periods of time up to a one-year maximum.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Bureau of Medical Care (medical assistance unit) is located in the Division of Medical Services of the State Department of Social Services. The Director of Welfare Medical Services (M.D.), who serves as chief of the Bureau, is directly responsible to the chief of the Division of Medical Services (Deputy Commissioner for Medical Services) who, in turn, is responsible to the First Deputy Commissioner of the Department. Professional staff of the Bureau consists of 1 full-time Social Services Consultant (medical care administration); 3 full-time Social Services Consultants (medical social work) and 3 full-time Pharmacy Consultants.</p>
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**D. Administration and Management (Continued)**

2. Supervision of Statewide Operations	Supervision of the <i>medical aspects</i> of the program is accomplished largely through activities of the Medical Care Section of the Department's area offices. Eligibility and fiscal aspects are handled by Family Services and Welfare Administration in the Area Offices. The State Health Department (see Item A.3., above) has responsibility for providing medical and dental directors to each local department. As required, other professional personnel may be provided, such as pharmacists, optometrists, and podiatrists.
3. Advisory Council	The State advisory body for title XIX is known as the Medical Advisory Council. It is composed of 20 members appointed by the Governor by and with the advice and consent of the Senate, and has no ex officio members. Authority for the Council derives from the New York Social Services Law, Article 5, Title 11, Section 365-c.
4. Buy-In Agreement	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
5. Claims Payment Process	<p data-bbox="491 688 1524 1045">a. State and Local Agencies The State Department of Social Services is not directly involved in the processing or payment of vendor claims for services provided under the program, but is responsible for supervising the activities of the local social services departments in the performance of these functions. Under the State's locally administered program, each local department is responsible for processing and payment of claims for the medical assistance it provides, and is free to select the method of doing so, subject to the State agency's approval. Method adopted by the local departments have varied. [Reporting on individual local agency practices is not included in this publication.] Payment for services provided to eligible patients in State Institutions for mental diseases and mental retardation are handled through direct appropriation by the New York State Legislature to the State Department of Mental Hygiene. (Waiver of the single State agency concept granted by the Secretary of the U.S. Department of Health, Education, and Welfare, under authority of Title II, Section 204, of the Intergovernmental Cooperation Act of 1968.)</p> <p data-bbox="491 1073 1501 1129">b. Fiscal Agents The State Department of Social Services has no fiscal agent agreements with non-governmental agencies. Adoption of such agreements by individual local departments is permissible.</p> <p data-bbox="491 1161 1501 1218">c. Prepaid Capitation Arrangements The State Department of Social Services has no arrangements for providing medical assistance through this method. Adoption of such method by individual local departments is permissible.</p> <p data-bbox="491 1276 1524 1625">d. Payments to Non-Medical Institutions The State Department of Social Services has no contractual arrangements with private non-medical institutions whereby direct payments would be made to the institutions for costs of providing specified types of medical care and services to eligible individuals. Local Social Services districts will execute contracts with private, non-profit, non-medical child-caring institutions which receive payments directly from Social Services districts. As of January 1, 1969, except for in-patient and out-patient hospital care, the child agency or institution will be required to pay the fees for services of medical practitioners who are not on the staff of the agency or institution. These expenditures will be included among the costs on which the medical per diem rate is determined. The cost of inpatient and outpatient hospital care as set forth in the rates promulgated by the State Department of Health shall be paid directly to the hospital by the Social Services district. Such costs not included in the promulgated rates is paid to the hospitals by the agencies and institutions concerned.</p>

**E. Financing**

1. Federal Financial Participation	The Federal Medical Assistance percentage for New York as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50%.
2. State/Local Participation	State and local funds are used in financing the non-Federal share of costs of both medical assistance and administration in the following proportions: 50% State funds, 50% local funds. <i>Except:</i> 100% State funds are used to meet the non-Federal share of costs attributable to providing medical assistance for eligible patients in institutions for the mentally ill and the mentally retarded operated by the Department of Mental Hygiene.

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**E. Financing (Continued)**

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<b>3. Source of State Funds</b>	State's share of program costs are derived from appropriations from State General Funds. Appropriations are made annually; unobligated balance may not be carried over to next fiscal year.
<b>4. Deficit Financing</b>	When additional funds are needed to meet a deficit before the next appropriation period, they are obtained through a Deficiency Appropriation Act passed by the State Legislature.

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## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Social Services

January 1, 1970

NORTH CAROLINA

**A. General Information**

<b>1. Legal Base</b>	North Carolina General Statutes, Chapter 108, Part 5
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1970. Original plan approved by the Federal agency on December 31, 1969.
<b>3. Administrative Responsibility</b>	<p>The State Department of Social Services serves as the single State agency with responsibility for supervising the administration of the program on a Statewide basis through 100 county Departments of Social Services.</p> <p>The State Commission for the Blind, which supervises the program of Aid to the Blind, has no administrative function relating to the determination of or certification of eligibility under title XIX; the county departments of social services (under the supervision of the State Department of Social Services) carry this function for persons eligible on account of blindness together with those eligible in relation to the other categories of public assistance.</p>
<b>4. Historical Background</b>	<p>The medical vendor payment program of the North Carolina State Board of Public Welfare began in 1951 with the provision of hospital care for recipients of OAA, APTD, and AFDC, and was expanded in 1961 to include "medical only" clients, i.e., persons meeting the eligibility requirements of these programs whose only budgetary deficit was related to the need for medical care. In 1963, statutory authority for vendor payments was substantially broadened by the State legislature to cover nursing care in licensed facilities, prescribed drugs, and outpatient clinic services for the OAA, APTD, and AFDC categories, and dental care for the OAA category. With the exception of nursing home care, this legislation was fully implemented between July 1964 and January 1965. A Federal-State program of Medical Assistance for the Aged (MAA), authorized by the 1963 legislature, was begun July 1, 1964, providing medical care (not including nursing home care) for persons age 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need.</p> <p>In the State's AB program, which is separately administered by the State Commission for the Blind, use of vendor payments began in 1957 as the method of providing dental care, prescribed drugs, and physicians' services related to eye care. Other needed medical care for AB recipients was made available only through the inclusion of a dollar amount in the recipient's money payment grant.</p> <p>In 1967, post-hospital care in an extended care facility (up to the limit of days covered as benefits under Medicare) was made available to recipients age 65 and older in all categories through payment of the Medicare co-insurance factor. Until the State's program under title XIX became operational in January 1970, other skilled nursing home care continued to be made available only through inclusion of a dollar amount in the recipient's money payment grant.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for mental diseases are provided only for patients who are 65 years of age or older. (Item B.4.c.)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.a.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B.8.(c); B.12.a., b. and c.; B.14.d.; and B.21.a.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. No limitations. Prior approval by State office required for cosmetic surgery and surgical transplants. Reimbursement on basis of reasonable cost. (Medicare cost reimbursement principles.) Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.</p> <p>Not provided.</p> <p>Provided. Limited to persons age 65 or older who are patients in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. (Medicare cost reimbursement principles.) Claims processed and paid by State Department of Social Services.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. Routine physical examinations and related laboratory and X-ray services are excluded. No other limitations. Prior approval by State office required for outpatient psychiatric consultation. Reimbursement on basis of reasonable cost (Medicare cost reimbursement principles). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. Routine physical examinations and related laboratory and X-ray services are excluded. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges (limited to payment of charges as claimed up to 75th percentile of charge range in State as of 1/1/69). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to persons age 21 or older. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (Medicare cost reimbursement principles); paid by State Department of Social Services. Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. Routine physical examinations and routine foot care excluded. Eye refractions included. No other limitations. Prior approval by State office required for cosmetic surgery, surgical transplants, and psychiatric consultation. Reimbursement on basis of usual, customary, and reasonable charges (limited to payment of charges as claimed up to 75th percentile of charge range in State as of 1/1/69). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>  <b>b. Optometrists</b>  <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Provided. Routine foot care not included. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges (limited to payment of charges as claimed up to 75th percentile of charge range in State as of 1/1/69). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.</p> <p>Provided. Limited to eye refractions and to giving of prescriptions for corrective lenses. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges (limited to payment of charges as claimed up to 75th percentile of charge range in State as of 1/1/69). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.</p> <p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed by fiscal agent (North Carolina Blue Cross Blue Shield, Inc.); paid by State Department of Social Services.</p> <p>Not provided.</p>
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided if furnished by certified home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (Medicare cost reimbursement principles). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.</p> <p>(b) Services of home health aide. Provided if furnished by certified home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (Medicare cost reimbursement principles). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. Limited to persons age 65 or older covered by State's buy-in agreement; consisting of rental or purchase of durable equipment and other items available as benefits under Medicare (Part B). Reimbursement on basis of reasonable and customary charges (as paid by Medicare). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); Medicare deductible and coinsurance paid by State Department of Social Services.</p>
<b>9. Private Duty Nursing Services</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Not provided.</p>
<b>11. Dental Services</b>	<p>Provided. Orthodontics excluded; also, all crowns not made of stainless steel. Prior approval by State office required for endodontics. Reimbursement on basis of usual, customary, and reasonable charges (limited to payment of charges as claimed up to 75th percentile of charge range in State as of 1/1/69). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.</p>
<b>12. Physical Therapy and Related Services</b>  <b>a. Physical Therapy</b>	<p>Provided. Limited to persons age 65 and older covered by State's buy-in agreement; and limited to services available as benefits under Medicare (Part B). No requirements for prior authorization. Reimbursement on basis of reasonable cost (as paid by Medicare). Claims processed by fiscal agent (North Carolina Blue Cross-Blue Shield, Inc.); Medicare deductible and coinsurance paid by State Department of Social Services.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Occupational Therapy</b>	Provided. Limited to persons age 65 and older covered by State's buy-in agreement; and limited to services available as benefits under Medicare (Part B). No requirements for prior authorization. Reimbursement on basis of reasonable cost (as paid by Medicare). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); Medicare deductible and coinsurance paid by State Department of Social Services.
<b>c. Speech Therapy</b>	Provided. Limited to persons age 65 and older covered by State's buy-in agreement; and limited to services available as benefits under Medicare (Part B). No requirements for prior authorization. Reimbursement on basis of reasonable cost (as paid by Medicare). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); Medicare deductible and coinsurance paid by State Department of Social Services.
<b>d. Audiology</b>	Not provided.
<b>13. Prescribed Drugs</b>	Provided. Limited to legend drugs and insulin. No requirements for prior authorization. Reimbursement to pharmacists on basis of acquisition cost (manufacturer's direct or wholesale price as shown in Drug Topics Red Book) plus a fixed dispensing fee of \$1.75 per prescription; to dispensing physicians (practicing in remote area and approved by State office for participation in drug program) on basis of acquisition cost, plus a fixed dispensing fee of \$1.75 per prescription. Claims processed and paid by State Department of Social Services.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. Including repair and replacement of broken glasses. No limitations, except that frames are restricted to zylonite (plastic) or a combination of zylonite and metal. Prior approval of State office required for subnormal visual aids and contact lenses. Payment made to opticians, optometrists, and dispensing physicians. Reimbursement on basis of wholesale cost of materials plus usual, customary, and reasonable charges for dispensing, up to specified maximums. Claims processed and paid by State Department of Social Services.
<b>b. Hearing Aids</b>	Not provided.
<b>c. Dentures</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary and reasonable charges (limited to payment of charges as claimed up to 75th percentile of charge range in State as of 1/1/69). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.
<b>d. Other Prosthetic Devices</b>	Provided. Devices to replace all or part of an internal organ, and other devices available as benefits under Medicare (Part B). Limited to persons age 65 or older covered by State's buy-in agreement; and limited to services available as benefits under Medicare (Part B). No requirements for prior authorization. Reimbursement on basis of reasonable and customary charges (as paid by Medicare). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); Medicare deductible and coinsurance paid by State Department of Social Services.
<b>15. Family Planning Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement to institutions on basis of reasonable cost (Medicare cost reimbursement principles); to practitioners on basis of usual, customary, and reasonable charges (limited to payment of charges as claimed up to 75th percentile of charge range in State as of 1/1/69). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (as paid by Medicare). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement; and limited to services covered as benefits under Medicare (Part B). No requirements for prior authorization. Reimbursement on basis of reasonable and customary charges (as paid by Medicare). Claims processed by fiscal agent (North Carolina Blue Cross and Blue Shield, Inc.); paid by State Department of Social Services.
<b>b. Other</b>	Not provided.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(6) Essential spouse [title XIX definition] of a recipient of AABD.</p>
<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of AABD.</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.

**C. Eligibility for Medical Assistance (Continued)**

<p><b>3. Coverage of the Categorically Needy</b></p> <p><b>a. FFP Claimed in Medical and Administrative Costs</b></p> <p><b>b. FFP Claimed in Administrative Costs Only</b></p>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of AABD and AFDC.</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving AABD or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of AABD. (Categorically needy only.)</p> <p>(8) Individuals age 65 or older who are patients in institutions for mental diseases. [Group covered for medical assistance under State's title XIX program but not covered for maintenance assistance under its AABD or AFDC programs.]</p> <p>(9) Persons who would be eligible for AABD or AFDC except that their budget deficit is less than the State's minimum payment of cash assistance under those programs. [State minimum payment is \$5.]</p> <p style="text-align: center;"><i>Optional</i></p> <p>(1) Essential spouse [title XIX definition] of a medically needy aged, blind, or disabled person [State definition].</p>
<p><b>4. Coverage of the Medically Needy</b></p>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Items C.3.a. and b., above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with regulations.</p>
<p><b>5. Financial Criteria</b></p> <p><b>a. For Categorically Needy Persons</b></p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>



**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p><b>(1) Income</b></p> <p>Annual income which may be retained for basic maintenance needs: \$1700 for one person, \$2200 for family of 2, \$2500 for 3, \$2800 for 4, and \$200 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$9.60 a month for personal expenses. Additional income may be applied to maintenance needs of dependents up to \$1700 for one dependent, \$2200 for 2 dependents, and higher amounts for additional dependents (according to progression stated in preceding paragraph).</p> <p>Application of persons with excess income may be accepted and approved, but medical assistance is not authorized until amount of the excess is spent or incurred (as evidenced by receipts or bills for medical expenses).</p> <p><b>(2) Resources</b></p> <p>Real property used as a home (defined as house and lot in city, or house and one acre in rural area) may be retained regardless of value or equity.</p> <p>Income-producing non-homestead property may be retained regardless of value or equity.</p> <p>Non-income-producing non-home property may be retained up to a maximum equity per family of \$2,000 in fair market value of the property.</p> <p>The following personal property is exempt regardless of value: Household furnishings and personal effects.</p> <p>A reserve of liquid assets (including cash surrender value of life insurance less encumbrances) may be held up to a combined value of \$1000 for one person, \$1100 for 2 persons, \$1150 for 3 persons, \$1200 for 4 persons, plus \$50 for each additional person.</p> <p>Resources in excess of these exemptions and allowable maximums render an individual ineligible.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>A Medicaid Card is mailed each month by the Data Processing Section of the State Department of Social Services to each case (individual or family) certified as eligible by a county department of social services. County certification indicates period of eligibility. Face of card lists each eligible person in the case by name and date of birth. Gummed eligibility labels showing month for which valid are attached to the Medicaid Card, one of which is to be detached by each provider at time of first visit during the month. In submitting claim for services rendered to patient during that month, provider enters patient's name and date of birth on face of claim, and affixes label to claim.</p> <p>Medicaid Cards for newly authorized cases are issued by the county department for interim period pending regular issuance by Data Processing Section.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Medical Services Division (medical assistance unit) is headed by a Director who is responsible to the Commissioner of the Department of Social Services. Professional staff of the Division consists of a full-time Director, a full-time Assistant Director (MSW), a part-time physician, and a part-time dentist. In addition, the following positions were established but not yet filled as of 1-1-70: 4 full-time professional staff (1 Medical Social Work Supervisor, 1 Mental Health Supervisor, and 2 Medical Social Work Consultants) and 2 part-time consultants (1 Psychiatrist, and 1 Pharmacist).</p>
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**D. Administration and Management (Continued)**

<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the activities of staff in 13 supervisory positions assigned to specific geographic areas throughout the State who are concerned with both eligibility and medical aspects of the program.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Advisory Committee for Medical Assistance. It is composed of 22 members appointed by the Governor. There are 5 ex officio members (Directors of the State Commission for the Blind, State Board of Health, Department of Public Instruction, Department of Administration, and Department of Mental Health). Authority for the Committee is statutory (Chapter 1040, Laws 1969).
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	Claims for drugs, eyeglasses, and services provided to eligible patients in institutions for mental diseases are processed by the State Department of Social Services, which makes final payment on all claims, including those processed by the Department's fiscal agent (see subsection b, below).
<b>b. Fiscal Agents</b>	North Carolina Blue Cross and Blue Shield, Inc., serves as fiscal agent for the State Department of Social Services. Fiscal agent is involved in the processing of all vendor claims except those for drugs, eyeglasses, and services provided in institutions for mental diseases. As to all other medical services provided under the program, the fiscal agent receives, processes, audits and approves the providers' claims for subsequent payment by the State Department of Social Services.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for North Carolina as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 73.96.
<b>2. State/Local Participation</b>	State funds are used to meet 100% of the non-Federal share of administrative costs of the program; of the non-Federal share of medical costs, 50% is met from county funds and 50% from State funds.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially. A specific amount is appropriated for conduct of the Medical Assistance program. Unobligated balance may be carried over within the biennium but reverts to the General Fund at the end of the biennium.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, additional funds may, with Advisory Board Commission action, be made available from Contingency and Emergency funds.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Public Welfare Board

January 1, 1970

NORTH DAKOTA

**A. General Information**

<b>1. Legal Base</b>	Chapter 7, Session Laws of North Dakota, 1965 (Extraordinary Session).
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1966. Original plan approved by the Federal agency on March 31, 1966.
<b>3. Administrative Responsibility</b>	The Public Welfare Board of North Dakota serves as the single State agency with responsibility for supervising the administration of the program on a Statewide basis through a system of local offices in the 53 counties.
<b>4. Historical Background</b>	<p>Vendor payments for the costs of medical care for recipients of OAA, AB, and AFDC with Federal financial participation in such payments began October 1, 1950. The State was one of the first to use this optional method authorized by a 1950 amendment to the Social Security Act. Such payments were made applicable to the APTD program when it began in January 1951 and were modified in 1957 and in 1958. By 1961 the scope of services was essentially the same in all four of the public assistance categories. The State statute authorized "all needed medical care," but there were some administrative limitations on duration of some services. Services were also available to persons who were eligible for one of the maintenance categories except that they had enough income to meet subsistence needs and needed help only to meet the costs of medical care. Such persons had to meet all the other eligibility requirements of the category to which they were related. In 1965, orthodontia was added to the scope of services for AFDC recipients "when the condition represents a substantial handicap."</p> <p>In July 1961 North Dakota began the Federal-State program of Medical Assistance for the Aged (MAA) for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. The applicant for MAA was required to "have paid or obligated himself to pay \$50 for medical care during the 12 months preceding the application". Benefits paid from health or hospital insurance were considered in the amount to meet this requirement. A full scope of services was provided.</p> <p>However, the legislation which authorized the MAA program specified that long-term nursing home care for all persons age 65 and older was to be provided only through MAA (along with short-term care for eligible MAA applicants) and that the nursing home care in the OAA program was limited to 30 days. Since under MAA only vendor payments to the suppliers of medical care could be made, and since concurrent receipt of assistance under OAA and MAA was prohibited in the Federal act, special arrangements were made by the State to meet the personal-care expenses of any OAA recipient who had no other source of income and was transferred to MAA in order to receive long-term nursing home care. The programs continued until the beginning of the title XIX program.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.; B.4.b. and c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p>

## B. Medical and Remedial Care and Services

<p><b>1. Inpatient Hospital Services</b></p> <p><b>a. In General Hospitals</b></p> <p><b>b. In Institutions for Tuberculosis</b></p> <p><b>c. In Institutions for Mental Diseases</b></p>	<p>Provided. No limitations. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Approval by State agency required for extension of hospitalization continuing beyond first 60 consecutive days and for each subsequent 30-day period. Reimbursement on basis of per diem rate established by State Public Welfare Board (based on hospital's annual cost statement). Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p> <p>Provided. Limited to patients age 65 or older in a licensed State institution for tuberculosis. No other limitations. Authorization by county welfare board required. Reimbursement on basis of reasonable cost. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment. [Note: Currently institution is unable to qualify and no payments are being made.]</p> <p>Provided. Limited to patients age 65 or older in State Hospital in Jamestown, North Dakota. No other limitations. Authorization by county welfare board required. Reimbursement on basis of cost-per-day rate which is reestablished annually. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed and paid by State Public Welfare Board.</p>
<p><b>2. Outpatient Hospital Services</b></p>	<p>Provided. No limitations. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement on basis of reasonable charges. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p>
<p><b>3. Other Laboratory and X-ray Services</b></p>	<p>Provided. No limitations. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement on basis of reasonable charges, not to exceed maximum fee established by application of \$5 per unit conversion factor to North Dakota Relative Value Guide. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p>
<p><b>4. Skilled Nursing Home Services.</b></p> <p><b>a. General</b></p> <p><b>b. In Institutions for Tuberculosis</b></p> <p><b>c. In Institutions for Mental Diseases</b></p>	<p>Provided. For persons of all ages. No limitations. Authorization by county welfare board required based on review and determination by Screening Team (established by county welfare board) as to type and level of care needed; review and evaluation made no later than 3 months after date of admission, and thereafter at least annually. Reimbursement on basis of cost, not to exceed a maximum of \$11.25 per day. All claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p> <p>Not provided.</p> <p>Not provided.</p>
<p><b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b></p>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>6. Physicians' Services</b> <b>(M.D. and D.O.)</b>	<p>Provided. No limitations. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement to Doctors of Medicine on basis of reasonable charges not to exceed maximum fee established by application of \$5 per unit conversion factor to North Dakota Relative Value Guide; to Doctors of Osteopathy on basis of negotiated fee schedule. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p>
<b>7. Services for Licensed Practitioners</b>  <b>a. Podiatrists</b>         <b>b. Optometrists</b>         <b>c. Chiropractors</b>         <b>d. Other</b>	<p>Provided. As furnished by certified home health agency or private practicing podiatrist. No limitations. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement to home health agency on basis of Certified Home Health Agency Fee Schedule (based on reasonable cost for each agency as determined by Medicare intermediary); of private practicing podiatrist on basis of negotiated fee schedule. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p> <p>Provided. No limitations. Authorization by county welfare board required. Reimbursement for services on basis of reasonable charge not to exceed maximum fee established by application of 10¢ per unit conversion factor to North Dakota Relative Value Guide; of materials on basis of invoice cost. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p> <p>Provided. No limitations. Authorization by county welfare board required (issued for not more than a 30-day period). Reimbursement on basis of negotiated fee schedule. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p> <p>Not provided.</p>
<b>8. Home Health Care Services</b>	<p>(a) Intermittent or part-time nursing service. Provided. As furnished by certified home health agency or, in the absence of such agency, by visiting nurse association or independent RN or LPN. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement to home health agency on basis of Certified Home Health Agency Fee Schedule (based on reasonable cost for each agency as determined by Medicare intermediary); of visiting nurse association and independent RN or LPN, on basis of reasonable charges based on prevailing rate in community. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p> <p>(b) Services of home health aide. Provided. As furnished by certified home health agency. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement on basis of Certified Home Health Agency Fee Schedule (based on reasonable cost for each agency as determined by Medicare intermediary). Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p> <p>(c) Medical supplies, equipment, and appliances. Provided when prescribed by a licensed practitioner for therapeutic treatment in connection with a specific medical condition. No other limitations. Prior authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement as charged but not to exceed retail price in the community. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>9. Private Duty Nursing Services (RN or LPN)</b>	Provided. To patient in hospital or own home. Not provided for patients in skilled nursing home. No other limitations. Prior authorization by county welfare board required (issued for not more than a 30-day period). Reimbursement on basis of reasonable charges not to exceed prevailing rate in community. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>10. Clinic Services (Other than Hospital)</b>	Provided. No limitations. Prior authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement as charged. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>11. Dental Services</b>	Provided. Orthodontia included. No limitations. Prior authorization by county welfare board required (issued for not more than a 30-day period). Reimbursement on basis of reasonable charges not to exceed maximum fee for services established by application of 10¢ per unit conversion factor to Dental Fee Schedule. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. No limitations. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement to home health agency on basis of Certified Home Health Agency Fee Schedule (based on reasonable cost for each agency as determined by Medicare intermediary); of private practicing physical therapist on basis of negotiated fee schedule. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>b. Occupational Therapy</b>	Provided. No limitations. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement to home health agency on basis of Certified Home Health Agency Fee Schedule (based on reasonable cost for each agency as determined by Medicare intermediary); of private practicing occupational therapist on basis of reasonable charges. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>c. Speech Therapy</b>	Provided. No limitations. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement to home health agency on basis of Certified Home Health Agency Fee Schedule (based on reasonable cost for each agency as determined by Medicare intermediary); of private practicing speech therapist on basis of reasonable charges. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>d. Audiology</b>	Provided. No limitations. Authorization by county welfare board required (issued for not more than a 30-day period except in case of Medicare-eligibles, for whom an "open authorization" is issued). Reimbursement as charged. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs. Limited to original prescription (no refills). No other limitations. Authorization by county welfare board required (issued for not more than a 30-day period). Reimbursement for legend drugs on basis of reasonable charges, not to exceed maximum established by "Public Welfare Board Uniform Maximum Drug Pricing Schedule"; for non-legend drugs on basis of retail price in the community. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.



**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Provided. As prescribed by an ophthalmologist, a physician skilled in diseases of the eye, or an optometrist. No limitations. Authorization by county welfare board required. Reimbursement on basis of Optometrists' Fee Schedule. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
b. Hearing Aids	Provided. Including batteries, other supplies, and replacements. No limitations. Authorization by county welfare board required. Reimbursement on basis of reasonable charges. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
c. Dentures	Provided. No limitations. Authorization by county welfare board required. Reimbursement on basis of reasonable charges not to exceed maximum established by application of 10¢ per unit conversion factor to Dental Fee Schedule. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
d. Other Prosthetic Devices	Provided. Apparatus which replaces or aids a part of the human body in carrying on its normal functions, such as artificial eyes, artificial limbs, braces, and special orthopedic shoes. No limitations. Authorization by county welfare board required. Reimbursement on basis of reasonable charges. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices. Separate authorization by county welfare board required for services of each provider utilized (e.g., physician, clinic, pharmacist). Basis of reimbursement variable according to provider utilized. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Limited to duration of emergency. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. Covers any non-identifiable items not specifically covered elsewhere in State title XIX Plan. Authorization by county welfare board required (issued for not more than a 30-day period). Reimbursement on basis of reasonable charges. Claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.
<b>21. Transportation</b>	
a. Ambulance	Provided. As furnished by hospital or other qualified provider. No limitations. Authorization by county welfare board required, except in the case of Medicare-eligibles. Reimbursement on basis of reasonable charges. Claims for Medicare deductible and coinsurance paid through insurance contract with Blue Cross and Blue Shield of North Dakota. All other claims processed by county welfare board and certified to State Public Welfare Board for final processing and payment.

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Other</b>	Provided. By taxicab, common carrier or other appropriate means. Including travel expenses as required, such as outside meals and lodgings enroute, and cost of an attendant. No limitations if necessary to obtain medical care. Authorization by county welfare board required. Reimbursement to common carrier on basis of prevailing rates; of private carrier on basis of reasonable charges; of attendant and purveyors of meals and lodgings as approved by the county welfare board. Claims processed by county welfare board and certified by State Public Welfare Board for final processing and payment.
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**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as seven days prior to the date of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a:
<b>a. Under age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in foster home or private institution for whom a public or private agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(6) Essential spouse [title XIX definition] of a recipient of AABD.</p>
<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of AABD.</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.



### C. Eligibility for Medical Assistance (Continued)

3. Coverage of the Categorically Needy	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
a. FFP Claimed in Medical and Administrative Costs	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of AABD and AFDC.</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving AABD or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(7) All children under age 21 in foster homes or private institutions for whom the cost of care is being met in whole or in part by public or private agency funds. (Limited to foster homes which are approved and private child-care institutions which are licensed by the Division of Children and Youth.)</p> <p>(8) Essential spouse [title XIX definition] of a recipient of AABD. (Categorically needy only.)</p>
b. FFP Claimed in Administrative Costs Only	<p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
4. Coverage of the Medically Needy	Coverage is extended to "medically needy" individuals, i.e. persons meeting the conditions of eligibility of one of the groups described in Items C.3.a. and b., above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.
5. Financial Criteria	The following criteria are used in establishing financial eligibility for medical assistance:
a. For Categorically Needy Persons	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.

**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p>(1) <i>Income</i></p> <p>Annual income which may be retained for basic needs: \$1600 for one person, \$2200 for family of 2, \$2600 for 3, \$3000 for 4, and \$400 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$8 a month for personal expenses. All additional income must be applied to costs of care in the facility. However, legal dependent or dependents at home are entitled to the usual income exemptions specified in the State plan.</p> <p>(2) <i>Resources</i></p> <p>Home and land on which it is located (up to 160 contiguous acres if rural, or 2 acres if in town) may be retained regardless of value or equity.</p> <p>Income-producing real and personal property is exempt from dollar limitations described below if unsaleable or if liquidation would reduce annual income below the limits protected for maintenance or otherwise cause undue hardship.</p> <p>Other real property (including excess home acreage) may be retained up to a net equity of \$2500 current market value.</p> <p>The following personal property is exempt regardless of value: Personal effects, wearing apparel, household goods, furniture, and trailer homes used for living quarters.</p> <p>Other personal property (including cash, savings, stocks, bonds, vehicles, machinery, live-stock, and cash surrender value of life insurance policies) may not exceed a total net equity of \$2500 current market value per family. Within this overall limitation, the total amount of liquid assets (e.g., cash, savings, redeemable stocks and bonds) may not exceed \$300 for one person, \$600 for 2 persons, plus \$50 each for the 3rd through the 10th family member, and \$25 for each additional member.</p> <p>Resources in excess of these amounts do not disqualify applicant from receiving medical assistance under the program but must be applied to cost of medical care. Nonliquid assets must be sold or funds borrowed against them.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>State does not issue medical assistance identification cards. The program requirement that a written authorization, valid for a specified period of time only, be obtained from the county welfare board by either the recipient or the provider at the time a particular type of medical service is needed assures that the individual served is currently eligible. A vendor claim for payment will not be processed for payment unless accompanied by such an authorization.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Director of Medical Services (a social worker) is directly responsible to the Executive Director of the State Public Welfare Board (the "single State agency"). Other professional staff are: a full-time Assistant Director of Medical Services (a social worker), a full-time Consultant on Adult Care Facilities, a full-time Nursing Consultant, a part-time Medical Consultant (M.D.), and a part-time Pharmaceutical Consultant.</p>
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of Statewide operations is accomplished through the consultants identified in Item D.1 above and the general supervisory and consultant staff of the State agency.</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Medical Care Advisory Committee. It is composed of 15 members appointed by the State Public Welfare Board. There are no ex officio members. Authority for the Committee is administrative.</p>



**D. Administration and Management (Continued)**

<b>4. Buy-in Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	With the exception of claims for services rendered to recipients age 65 and older involving Medicare benefits, all claims are subjected to an initial review by the county welfare boards and are then certified to the State Public Welfare Board for payment. Initial processing by the county boards consists of verification that a properly edited authorization is attached to the claim, audit and correction of vendor charges according to the State Public Welfare Board's regulations and fee schedules, and the entry of any credits to be applied toward payment of the bill.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	The Public Welfare Board of North Dakota has entered into a <i>joint</i> insurance contract with Blue Cross of North Dakota and North Dakota Physicians Service (Blue Shield) whereby the insurer agrees, in consideration of the payment of a monthly premium of \$9.60 on behalf of each person age 65 or older certified by the Board as eligible under its title XIX program, to pay the full amount of any Medicare (Part A and B) deductible or coinsurance for which such persons become obligated.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for North Dakota as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 70.48.
<b>2. State/Local Participation</b>	The non-Federal share of costs of operating the program are met through State and local funds as follows: For costs of medical assistance provided, 85% State funds and 15% local funds; for costs of administration, 46% State funds and 54% local funds.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially from general funds of State. Unobligated balance may be carried over within the biennium but reverts to the General Fund 30 days after the close of the biennial period.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, an appeal can be made to the Emergency Commission. If funds are not made available to meet the deficit, vendor payments would be discounted wherever possible. State law prohibits the Department from making encumbrances in excess of amount appropriated.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

OHIO

**A. General Information**

<b>1. Legal Base</b>	Section 5101.51, Ohio Revised Code (enacted pursuant to Amended Substitute House Bill No. 915, approved August 6, 1965, effective November 5, 1965).
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on May 15, 1966.
<b>3. Administrative Responsibility</b>	The Department of Public Welfare serves as the single State agency with responsibility for supervising the administration of the program by 88 county departments of welfare.
<b>4. Historical Background</b>	<p>Payments to providers of medical care in behalf of OAA recipients, with Federal financial participation, were made as early as April 1, 1952. In 1956 the State adopted the "pooled fund" method of financing the costs of care, and in September 1957 revised the plan and extended "pooled fund" payments and medical services to the AB and APTD programs. The "pooled fund" was closed out in October 1958 when there was a change in Federal financial participation to a "general averaging formula per recipient". Medical services for the AFDC program were covered briefly by vendor payment provisions, beginning in May 1959 and ending in January 1960. By 1961, a comprehensive scope of services, with limitations on the amount of some services, was being provided for the three adult categories except that nursing home care was provided only through the money payment to recipients. In January 1962 the full scope of medical services available under the AB and APTD categories was reinstated for the AFDC program. By April 1964, the State was using vendor payments for services to OAA recipients in public or private "chronic care hospitals" as a form of nursing home care; but for persons in other licensed medical care nursing homes, provision continued to be made in the money payment to the recipient until the beginning of the title XIX program.</p> <p>The same scope of services provided to OAA recipients was made available in October 1960 to aged persons who met all the eligibility conditions for OAA except that their income and resources were sufficient to meet their maintenance needs and their need of assistance was a result of the costs of necessary medical care of a kind recognized in the State's public assistance plan. Because of this extension of OAA to the "medical only" cases, the State Legislature did not enact the bills introduced in the 1961 session and in the 1963 session for a Federal-State program of Medical Assistance for the Aged. (This Federal-State program was designed for persons age 65 and older who were not recipients of public assistance but who met certain criteria of medical and financial need.) This extension of OAA continued until the beginning of the title XIX program.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and B.4.c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Item B.12.b. and c.)</p>



**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For each spell of illness up to a total of 90 days. No provision for vendor payment beyond 90 days. Prior authorization is required for hospitalization of dental patients, except in emergencies. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.</p> <p>Not provided.</p> <p>Provided. Limited to patients age 65 or older in State institutions. No limit on length of stay as long as care is necessary. Reimbursement on basis of per diem rate based on cost. Claims processed and paid by State Department of Public Welfare.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. No limitations. Prior authorization by county department required for materials dispensed (limited to drugs for use at home, eyeglasses, dentures, braces, and prostheses); not required for services. Reimbursement on basis of \$10 a visit, plus extra payment for allowable dispensed materials. Claims processed and paid by State Department of Public Welfare.</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. As furnished by a Medicare-certified independent laboratory. No limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable fees, within established maximum levels. Claims processed and paid by State Department of Public Welfare.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For persons of all ages, in private and public institutions meeting standards. Must be on physician's recommendation and prior authorization by State welfare department required. Reimbursement on basis of fixed rate of \$14 per day for maximum care and \$9 per day for average care (effective April 1, 1970) as specified in Appropriation Act for the biennium 7/1/69 to 6/30/71. (Public institutions, \$11 per day for maximum care and \$8 per day for average care.) Claims processed and paid by State Department of Public Welfare.</p> <p>Not provided.</p> <p>Provided. In private and public institutions meeting standards; nursing home must be licensed as a mental nursing home. Must be on physician's recommendation and prior authorization required by State welfare department. Reimbursement on basis of fixed rate of \$14 per day for maximum care and \$9 per day for average care (eff. April 1, 1970) as specified in Appropriation Act for the biennium 7/1/69 to 6/30/71. (Public institutions, \$11 per day for maximum care and \$8 per day for average care.) Claims processed and paid by State Department of Public Welfare.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. Limited to maximum of 10 visits per month. Routine physical examination of a mass screening nature excluded. No requirements for prior authorization. Reimbursement on basis of 60% of usual, customary, and reasonable fees, except that percentage is not applied to reduce charge for a visit below \$5. (Payment on the basis of prevailing charges up to the 75th percentile, effective October 1, 1970). Use of standard preprinted punched card billing form (furnished by State department) is optional. Claims processed and paid by State Department of Public Welfare.</p>

**B. Medical and Remedial Care and Services (Continued)**

<p><b>7. Services of Licensed Practitioners</b></p> <p><b>a. Podiatrists</b></p> <p><b>b. Optometrists</b></p> <p><b>c. Chiropractors</b></p> <p><b>d. Other</b></p>	<p>Provided. Subject to same limitations as apply to such practitioner's services under Medicare (i.e., routine foot care, subluxations, treatment of flat feet, and prescription of supportive devices are excluded). Prior authorization from State welfare department required for procedures not covered by Schedule of Maximum Payments, for all cases except those persons receiving such services as Medicare benefits. Podiatrist's billings must be on standard preprinted punched card billing form (furnished by State department). Reimbursement on basis of Schedule of Maximum Payments. Claims processed and paid by State Department of Public Welfare.</p> <p>Provided. No limitations. Prior authorization by county welfare department required for materials costing under \$21 and for all professional services; by State department for materials costing \$21 or more. Reimbursement on basis of Schedule of Maximum Payments. Optometrist's billing must be on standard preprinted punched card billing form (furnished by State department). Claims processed and paid by State Department of Public Welfare.</p> <p>Provided. No limitations. Prior authorization by county welfare department required. Reimbursement on basis of 60% of usual, customary, and reasonable fees except that the percentage is not applied to reduce charge for a visit below \$5. Claims processed and paid by State Department of Public Welfare.</p> <p>Provided. Services of other limited practitioners may be provided only under written referral of physician. [To date, no payments have been made to any of these practitioners.] Prior authorization by local welfare department required. Reimbursement on basis of 60% of usual, customary, and reasonable fee, except that the percentage is not applied to reduce charge for a visit below \$5. Claims processed and paid by State Department of Public Welfare.</p>
<p><b>8. Home Health Care Services</b></p>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. As furnished by a home health agency. No limitations. No requirements for prior authorization for services furnished as Medicare benefits to persons age 65 or older covered by State's buy-in agreement; in all other cases, authorization by local welfare department required after first 10 visits (combined total of home health agency visits of all types) and after second month. Reimbursement on basis of reasonable charges, based on cost figures determined for Medicare, but not to exceed \$7 per visit. Claims processed and paid by State Department of Public Welfare.</p> <p>(b) Services of home health aide. Provided. As furnished by a home health agency. No limitations. No requirements for prior authorization for services furnished as Medicare benefits to persons age 65 or older covered by State's buy-in agreement; in all other cases, authorization by local welfare department required after first 10 visits (combined total of home health agency visits of all types) and after second month. Reimbursement on basis of reasonable charges, based on cost figures determined for Medicare, but not to exceed \$7 per visit. Claims processed and paid by State Department of Public Welfare.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. Must be recommended by attending physician. No limitations, except that medical equipment and supplies may be provided for home use only. Prior authorization for medical supplies not required; but prior authorization required from State office for all equipment and appliances. Reimbursement on basis of usual charge in the community. Claims processed and paid by State Department of Public Welfare.</p>
<p><b>9. Private Duty Nursing Services (RN or LPN)</b></p>	<p>Provided. In hospital or in patient's own home, but not in skilled nursing home or intermediate care facility. Must be prescribed by attending physician. No other limitations. Prior authorization by county welfare department required. Reimbursement on basis of current rate in the community. Claims processed and paid by State Department of Public Welfare.</p>
<p><b>10. Clinic Services (Other than Hospital)</b></p>	<p>Provided. Limited to services provided in public health department clinics. Routine periodic or screening physical examinations excluded. No requirements for prior authorization. Reimbursement on basis of Schedule of Maximum Payments. Claims processed and paid by State Department of Public Welfare.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>11. Dental Services</b>	Provided. Orthodontia excluded. No other limitations. Prior authorization by State department required for dentures (upper and lower), partial dentures, other prosthetic dental services, and any procedure not listed on Schedule of Maximum Payments. Reimbursement on basis of practitioner's usual and customary fee, but not to exceed Schedule of Maximum Payments. Dentist's billings must be on standard preprinted punched card billing form (furnished by State department). Claims processed and paid by State Department of Public Welfare.
<b>12. Physical Therapy and Related Services</b>	
a. Physical Therapy	Provided. As furnished by home health agency. No limitations. No requirements for prior authorization for services furnished as Medicare benefits to persons age 65 or older covered by State's buy-in agreement; in all other cases, authorization by local welfare department required after first 10 visits (combined total of home health agency visits of all types) and after second month. Reimbursement on basis of reasonable charges, based on cost figures determined for Medicare, but not to exceed \$7 per visit. Claims processed and paid by State Department of Public Welfare.
b. Occupational Therapy	Provided. As furnished by home health agency. Limited to persons age 65 or older covered by State's buy-in agreement and to such services when available as Medicare benefits.
c. Speech Therapy	Provided. As furnished by home health agency. Limited to persons age 65 or older covered by State's buy-in agreement and to such services when available as Medicare benefits.
d. Audiology	Provided. Limited to hearing examinations, as provided by a physician or Speech and Hearing Clinic facility. No requirements for prior examination. Reimbursement of clinic on basis of \$10 per examination; of physicians, on basis of 60% of usual, customary, and reasonable fee. Claims processed and paid by State Department of Public Welfare.
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs prescribed by a physician, dentist, or podiatrist. Prescription not to exceed 30-day supply in nursing home. No other limitations. No requirements for prior authorization. Reimbursement to retail pharmacy on basis of wholesale cost plus 50%; plus additional 30¢ broken lot charge if quantity prescribed is not a standard package quantity or multiple thereof; minimum charge of \$1.00 (includes broken-lot charge); total not to exceed charges to general public. Reimbursement to hospital pharmacies and public health departments not to exceed wholesale costs as listed in Blue Book and Red Book. Retail pharmacy billing must be on standard preprinted punched card billing form (furnished by State department). Claims processed and paid by State Department of Public Welfare.
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Provided. No limitations. Prior authorization by local welfare department required for examinations and materials costing under \$21; by State department for materials costing \$21 or more. Payments made to ophthalmologists, optometrists, and opticians. Reimbursement on basis of Schedule of Maximum Payments and based on cost of material. Optometrist's and optician's billing must be on standard preprinted punched card billing form (furnished by State department). Claims processed and paid by State Department of Public Welfare.
b. Hearing Aids	Provided. Must be prescribed by physician and recommended by speech and hearing center. No limitations. Prior authorization by State office required. Batteries for hearing aids provided without authorization. Reimbursement on basis of usual charge in community. Claims processed and paid by State Department of Public Welfare.
c. Dentures	Provided. No limitations. Prior authorization by State department required for dentures; not required for repair of dentures. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.
d. Other Prosthetic Devices	Provided. Must be recommended by attending physician. Consisting of prosthetic devices to replace all or part of a body organ; braces, orthopedic shoes; artificial limbs, artificial eyes; and replacements as required by change in patient's condition. Prior authorization by State office required. Reimbursement on basis of usual charge in community. Claims processed and paid by State Department of Public Welfare.

**B. Medical and Remedial Care and Services (Continued)**

<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices. No limitations. No requirements for prior authorization. Reimbursement of physicians on basis of 60% of usual, customary, and reasonable fees; of pharmacists on basis of wholesale cost plus 50%, but total not to exceed charges to general public. Nominal fee paid to planned parenthood agencies for drug supplies and devices. Claims processed and paid by State Department of Public Welfare.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. In emergency situations only. Not to exceed 90 days. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
a. Ambulance	Provided. When required due to patient's condition and prescribed by a physician. No other limitations. Prior authorization required for situations other than transportation to or from a hospital, or in emergency situations. Reimbursement on basis of usual and customary fee in the community. Claims processed and paid by State Department of Public Welfare.
b. Other	Not provided.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
a. Under Age 21	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of the father.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition) and age 18 or older.</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p>



**C. Eligibility for Medical Assistance (Continued)**

b. Age 21 to 64	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
c. Age 65 or older	(1) Individual who has attained age 65.
<p>3. Coverage of the Categorically Needy</p> <p>a. FFP Claimed in Medical and Administrative Costs</p> <p>b. FFP Claimed in Administrative Costs Only</p>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
4. Coverage of the Medically Needy	Not included.
5. Financial Criteria	The following criteria are used in establishing financial eligibility for medical assistance:
a. For Categorically Needy Persons	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
b. For Medically Needy Persons	Not applicable.
6. Financial Responsibility of Relatives	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.
7. Identification to Vendors of Persons Eligible	A Health Service Card is issued each month by the State office to all persons and families certified as eligible for medical assistance. Face of card shows case name and number, names of all individuals eligible, assistance category, and expiration date.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Chief of the Division of Medical Assistance (the medical assistance unit) who is from the field of hospital administration (MHA) is responsible to the Director of the Department of Public Welfare. The full-time professional staff consists of: a Medical Consultant (M.D.), an Assistant Chief (Social Administration), 2 Administrative Assistants (1 Hospital Administration; 1 R.N.), Supervisor of Medical Consultation Unit (MSW), Supervisor of Psychiatric Unit (Psychiatric Social Worker), Dental Consultant (D.D.S.), 4 Nursing Consultants (R.N.), 2 Pharmaceutical Market Consultants (1 Pharmacist; 1 Business Administration), and 2 Utilization Review Specialists. In addition the services of the following consultants are available on a part-time basis: 9 physicians who are specialists in different fields of practice, including psychiatry; 1 doctor of osteopathy; 1 dentist; 2 optometrists; and 1 podiatrist.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the district offices of the Department of Public Welfare with 12 Medical Assistance Consultants, assigned 2 or 3 to each District. These staff members are qualified as RN's, in rehabilitation services, or in fields of administration of health, education, or welfare.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Assistance Advisory Committee. It is composed of 13 members appointed by the Director of the State Department of Public Welfare, with the approval of the Governor. There is one ex officio member (Director, Department of Public Health). Authority for the Committee is administrative.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Public Welfare processes and pays all medical vendor claims for services provided under the program.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Ohio as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 52.42.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of medical assistance provided. Non-federal share of administrative costs is met on the basis of 90% State funds (minimum) and 10% county funds (maximum).
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations to the Department of Public Welfare made biennially from general revenue fund money, with the amount appropriated for health care separately specified for each of the two fiscal years. Balances may be transferred from one year to another, if approved by the Controlling Board.
<b>4. Deficit Financing</b>	If additional funds are needed before the next appropriation period in order to continue the expenditure level attained under existing policies, the State controlling board may release funds from later fiscal year quarters or authorize transfers from other appropriated funds in which an excess is available. A projected deficit in excess of appropriations may be incurred only with assurance of the State Finance Department that funds will be provided. This is under continuous review.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Institutions, Social  
and Rehabilitative Services

January 1, 1970

OKLAHOMA

### A. General Information

1. Legal Base	Oklahoma Constitution, Article 25; and Executive Order of Governor Henry Bellmon, November 22, 1965.
2. Beginning Dates	Program went into operation on January 1, 1966. Original plan approved by the Federal agency on March 31, 1966.
3. Administrative Responsibility	The State Department of Institutions, Social and Rehabilitative Services serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices in 77 counties.
4. Historical Background	<p>Vendor payments for the cost of medical care for recipients of OAA, AB, APTD, and AFDC were used first in July 1957. The services were inpatient hospital care (limited to life-endangering or sight-endangering conditions) and physicians' services. During the next three years other services were added, so that by 1961 the scope of services included inpatient hospital care for OAA, AB, APTD, and adults in AFDC to treat a condition which endangered life or sight or, for adults in AFDC, to provide treatment for self-help or self-care and for children in AFDC, treatment to prevent or correct a crippling condition; physicians' services; dental care, limited to conditions requiring oral surgery performed in a licensed general hospital; special nursing services in the home; prescribed drugs for AFDC children; and the "medical component" of nursing home care, with the "room and board component" of the costs of care being provided through the money payment to the recipient for total needs.</p> <p>The State used a "pooled fund" into which premiums were deposited each month for each recipient. Then from this fund, plus the Federal financial matching of the premiums, payment was made to the suppliers of medical care and services. The Federal-State "pooled fund" was liquidated in 1964, but the State continued an agency pooled fund as a convenience.</p> <p>In October 1960, the State implemented the Federal-State program of Medical Assistance for the Aged (MAA) for persons age 65 and older who were not recipients of public assistance but met certain criteria of financial and medical need. The scope of services was essentially the same as that provided under the OAA program except that nursing home care was limited to 6 months of care within a 12-month period and there were durational limits on inpatient hospital care and physicians' services. The program continued until the implementation of the title XIX program.</p>
5. Scope of Coverage	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement.</p> <p>Certain services provided for categorically needy persons are not made available to medically needy persons.</p> <p>Certain services provided for categorically needy persons are made available on a more limited basis to medically needy persons.</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>          <b>b. In Institutions for Tuberculosis</b>   <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For persons age 65 or older, provided through payment of Medicare deductible, with no requirements for prior authorization. For persons under age 21, limited to 10 days per admission, with authorization by State office, plus extension up to 10 additional days upon prior approval of State agency. For all others (including Medicare beneficiaries for whom benefits are not currently available or are available only with coinsurance liability), limited to 10 days per admission, except for therapeutic radiology. With the exception of services received as Medicare benefits, the following limitations and exclusions are imposed: (1) Minimum of 20-day lapse required between date of admission and date of last previous hospital discharge, except for therapeutic radiology; (2) Hospitalization for cosmetic surgery is excluded as well as for treatment of tuberculosis, mental illness (other than for acutely depressed suicidal patient), and eye conditions other than those conducive to blindness or serious impairment of sight; (3) Payment made only to hospitals which have a participation agreement and, in case of children under age 21, a contract to participate in Crippled Children's Program; (4) No payment for non-emergency services provided in hospitals located beyond 50 miles of State border. Reimbursement on basis of reasonable cost (as computed and paid by Medicare). Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. For persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, provided through payment of Medicare deductible and coinsurance. For all others, limited as follows: (1) For money payment recipients and children under age 21, therapeutic radiology (for a proven malignancy), obstetrical care, hemodialysis, and emergency room services (all-inclusive care immediately following an acute physical injury), and (2) For non-money-payment recipients, limited to therapeutic radiology (for a proven malignancy), obstetrical care, and hemodialysis. No payment for outpatient emergency services if patient admitted to same hospital within 24 hours. Reimbursement on basis of reasonable cost up to maximum of \$5.50 for use of emergency room, plus \$15 for X-rays, and \$7.50 for laboratory services; hemodialysis on basis of reasonable costs to hospital, subject to retroactive adjustment, and reasonable charges to physicians. Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. For persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, provided through payment of Medicare deductible and coinsurance. For all others, limited to money-payment recipients and to emergency services following an acute physical injury. Reimbursement of Medicare deductible and coinsurance on basis of reasonable charges (as computed and paid by Medicare); reimbursement for services provided to others, on same basis. Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>       <b>b. In Institutions for Tuberculosis</b>   <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For persons of all ages. In skilled nursing homes which have entered into a participation agreement with the State agency. No limitations. Prior authorization from State office required (except for persons age 65 or older receiving Medicare-covered services in extended care facilities). Reimbursement on basis of negotiated fee schedule. Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p> <p>Not provided.</p> <p>Not provided.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Provided. For any child under age 21 needing diagnostic or treatment services; through combination of State's title XIX program and its Crippled Children's Program. Referrals are received from private practitioners, Health Department personnel, school nurses, other public and private agencies, and Department staff engaged in providing services of the agency to the public.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. For persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, provided through payment of Medicare deductible and coinsurance. For all others, services (including therapeutic radiology rendered in physician's office) provided within the following limitations and exclusions:</p> <p>(1) Limitations:</p> <ul style="list-style-type: none"> <li>(a) Services for hospital inpatients. Provided for all eligible persons. Limited to obstetrical care, and either surgical care (including pre- and post- operative care) or one visit per day for 10 consecutive days per admission. Payment limited to total of \$1000 for surgery performed on any given day on one patient and total of one visit per day for medical care.</li> <li>(b) Visits to patients in nursing homes. Provided for all eligible persons. Limited to 2 visits per month. Payment for visit to non-money payment recipient not to exceed \$5 of unmet portion of physician's charge.</li> <li>(c) Visits in home, office, or elsewhere. Provided for all children under age 21, and for recipients of (and persons whose needs are included in) a money payment grant. Limited to maximum of 4 visits per month.</li> <li>(d) Outpatients' physicians services for non-money payment recipients limited to obstetrical care, therapeutic radiology, and hemodialysis.</li> </ul> <p>(2) Exclusions:</p> <ul style="list-style-type: none"> <li>(a) Cosmetic surgery; treatment of tuberculosis; treatment of mental illness (other than inpatient care for acutely depressed suicidal patient); treatment of eye condition other than those conducive to blindness or serious impairment of sight.</li> <li>(b) Consultation examinations; surgical assistant service; services of two physicians at same time to same patient for same type of service (unless warranted by necessity for supplementary skills); outpatient visit and admission to hospital on same date; physicians services provided more than 50 miles outside State border (except in emergencies).</li> <li>(c) Injections; all inpatient and outpatient services for diagnostic study; diagnostic X-ray, laboratory work, tissue examination, ECG's, physical therapy, and all other ancillary services.</li> </ul> <p>Reimbursement on basis of reasonable charges. Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>   <b>b. Optometrists</b>  <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Provided. For persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, provided through payment of Medicare deductible and coinsurance. For all others, limited to services provided by private-practicing podiatrists to money-payment recipients while in hospital. Prior authorization by State office required for services rendered to persons under age 21. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p> <p>Not provided.</p> <p>Not provided.</p> <p>Not provided.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipients while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided only for persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, when provided by a certified home health agency and available to enrollee as a Medicare benefit. No requirements for prior authorization. Reimbursement on basis of reasonable cost (as computed and paid by Medicare). Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p> <p>(b) Services of home health aide. Provided only for persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, when provided by a certified home health agency and available to enrollee as a Medicare benefit. No requirements for prior authorization. Reimbursement on basis of reasonable cost (as computed and paid by Medicare). Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p> <p>(c) Medical supplies, equipment, and appliances. Provided only for persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, when available to enrollee as a Medicare benefit. No requirements for prior authorization. Reimbursement on basis of reasonable charges (as computed and paid by Medicare). Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p>
<b>9. Private Duty Nursing Services (RN and LPN)</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided only for persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, when available to enrollee as a Medicare benefit. No requirements for prior authorization. Reimbursement on basis of reasonable charges (as computed and paid by Medicare). Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p>
<b>11. Dental Services</b>	<p>Provided. Limited to (1) dental surgery relating to the jaw and intraoral cavity, or reduction of fracture of the jaw or any related facial bone, for life-endangering conditions, when performed on an inpatient hospital basis in an eligible participating hospital, and (2) emergency outpatient dental services (X-rays and extractions), not to exceed \$300 per month per dentist, for public assistance recipients age 21 or over. Prior authorization by local office required (except for Medicare-eligibles) for non-emergency services. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p>
<b>12. Physical Therapy and Related Services</b>	<p><b>a. Physical Therapy</b></p> <p>Provided only for persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, when available to enrollee as a Medicare benefit. No requirements for prior authorization. Reimbursement on basis of reasonable charges (as computed and paid by Medicare). Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p> <p><b>b. Occupational</b></p> <p>Provided only for persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, when available to enrollee as a Medicare benefit. No requirements for prior authorization. Reimbursement on basis of reasonable charges (as computed and paid by Medicare). Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p> <p><b>c. Speech Therapy</b></p> <p>Provided only for persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, when available to enrollee as a Medicare benefit. No requirements for prior authorization. Reimbursement on basis of reasonable charges (as computed and paid by Medicare). Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.</p> <p><b>d. Audiology</b></p> <p>Not provided.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>13. Prescribed Drugs</b>	Not provided.
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Not provided.
b. Hearing Aids	Not provided.
c. Dentures	Not provided.
d. Other Prosthetic Devices	Provided. For persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, such items when available to enrollee as a Medicare benefit. For all others, limited to pacemakers and prostheses used in course of surgical procedure during a period of compensable hospitalization. Reimbursement on basis of reasonable charges (as computed and paid by Medicare). Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.
<b>15. Family Planning Services</b>	Not provided.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Not provided.
<b>19. Personal Care Services In Patient's Home</b>	Provided. Non-technical medical care provided to patient in own home by an individual (not a member of patient's family) certified by a physician as competent to provide non-technical personal care. Prior authorization by State office required. Reimbursement on basis of negotiated rate (\$3 per day plus \$1.50 per day for each of one or two additional persons receiving such care in same home). Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
a. Ambulance	Provided. For persons age 65 or older enrolled (voluntarily or through State's buy-in agreement) under Title XVIII, Part B, provided through payment of Medicare deductible and coinsurance, with no requirement for prior authorization. For all others, provided for children under 21 and adult money-payment recipients, with prior authorization by local office required for non-emergency services. Not provided for adult non-money-payment recipients. Reimbursement on basis of negotiated rate. Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Other</b>	Provided. By bus, railway, or other common carrier. Not provided for non-money-payment recipients over age 21, nor for any person over age 65. Provided for all persons under age 65 who are included in a money payment grant and for all other persons under age 21, plus (1) meals and overnight lodgings enroute when necessary to obtain services at a medical facility, and (2) subsistence when necessary for person requesting nursing services to receive a medical examination outside the city limits of his residence. Prior authorization by local office required. Reimbursement for transportation on basis of going rate charged by common carrier; for meals and lodging on basis of negotiated rate and/or fee schedule. Claims processed and paid by State Department of Institutions, Social and Rehabilitative Services.
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**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the third month prior to the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
	(1) Individual under age 21.
	(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father. (2) Person who is blind (State definition). (3) Person who is permanently and totally disabled (State definition). (4) Essential spouse [title XIX definition] of a recipient of AABD.
	(1) Individual who has attained age 65.
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
	<p style="text-align: center;"><i>Mandatory</i></p> (1) Recipients of AABD and AFDC. (2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX. (3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.
	<p style="text-align: center;"><i>Optional</i></p> (4) Persons eligible for but not receiving AABD. (5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC program but who would be eligible for such assistance if they left the facility. (6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living. (7) All individuals under age 21. (8) Essential spouse [title XIX definition] of a recipient of AABD. (Categorically needy only.)
	<p style="text-align: center;"><i>Optional</i></p> None.
<b>b. FFP Claimed in Administrative Costs Only</b>	None.



## C. Eligibility for Medical Assistance (Continued)

4. Coverage of the Medically Needy	Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a., above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.
5. Financial Criteria	The following criteria are used in establishing financial eligibility for medical assistance:
a. For Categorically Needy Persons	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
b. For Medically Needy Persons	<p>(1) <i>Income</i></p> <p>Persons living in their own home may retain annual income up to \$1000 for one person, \$1700 for family of 2, \$2100 for 3, \$2600 for 4, \$3000 for 5, \$3400 for 6, \$3800 for 7, \$4100 for 8, and \$4400 for 9 or more.</p> <p>Persons living in a rented home may retain annual income up to \$1300 for one person, \$2000 for a family of 2, \$2500 for 3, \$3000 for 4, \$3400 for 5, \$3900 for 6, \$4300 for 7, \$4600 for 8, and \$4800 for 9 or more.</p> <p>Person in chronic (long term) care in a medical facility may retain \$43 a month for his own needs (\$12 for personal items, \$14 for clothing, and \$17 for basic drugs). Additional income may be applied to maintenance needs of dependent <i>living in own home</i>, up to \$1000 per year for one dependent, \$1700 for 2, and so on as given for family size above up to \$4400 for 9 or more dependents or, for dependents <i>living in a rented home</i>, up to \$1300 per year for one dependent, \$2000 for 2, and so on as given above for family in a rented home up to \$4800 for 9 or more dependents. Excess income must be applied to costs of medical care.</p> <p>(2) <i>Resources</i></p> <p>Real property owned and used as a shelter, together with up to 40 acres of land directly associated with shelter, may be retained up to an equity of \$8000 (based on current market value).</p> <p>The following personal resources are exempt: One milk cow or goat, 50 hens, and one hog; home produce from garden, livestock, and poultry, if used for family consumption; household goods, clothing, and personal effects.</p> <p>Other resources (liquid and non-liquid, income-producing and non-income-producing) may be retained as a savings reserve up to a total value of \$500 for one person, \$700 for 2 persons, \$800 for 3, \$900 for 4, \$1000 for 5, \$1100 for 6, \$1200 for 7, \$1300 for 8, \$1400 for 9 or more. The term "other resources" includes but is not limited to non-home real property, excess shelter acreage, savings accounts, stocks, bonds, cash value of life insurance, mineral rights, farm equipment, and an automobile.</p> <p>Resources in excess of these amounts do not disqualify applicant but must be applied to costs of medical care. A reasonable time is permitted for liquidating capital assets.</p>
6. Financial Responsibility of Relatives	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.

### C. Eligibility for Medical Assistance (Continued)

<b>7. Identification to Vendors of Persons Eligible</b>	<p>Medical Identification Cards are issued by the local offices to all money-payment recipients at the time the clients become eligible for services and at other times when the composition of the family changes. The case name, the agency identification number, and the name, sex, and birth-date of each eligible person in the case are shown on the card. The following statement also appears on the card: "non-transferable under Penalty of Law." Identification cards are not issued to medical-only cases, since they are certified as eligible at each episode of illness for the duration of the current illness only. Such persons receive a "Notification of Eligibility Status for Medical Assistance," which gives a statement of the amount, if any, of the applicant's excess income which he is expected to apply toward payment of his own medical expenses. Recipients with excess income are required to designate the names of the providers from whom they chose to receive medical care and to specify the dollar amount of their excess income which they intend to apply to each (or one or more) of these providers. Vendors so chosen receive a "Notification of Needed Medical Services" from the State agency informing them of the patient's eligibility and stating the amount, if any, of their medical claim for which the State agency will not be responsible but for which they must look to the patient for payment.</p>
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### D. Administration and Management

<b>1. Medical Assistance Unit</b>	<p>The director of the Medical Assistance Unit is a physician who is responsible to the Director of the Department. The other full-time professional staff consists of a Supervisor of Medical Assistance (M.D.), a Supervisor-Compensable Physicians' and Hospital Services, a Supervisor of Eligibility for "Medical Assistance Only" (Social Worker). These are assisted by part-time staff: Supervisor of Medical Units (M.D.), Supervisor of Crippled Childrens Services (M.D.), and three Consultants (M.D.).</p>								
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of Statewide operations is accomplished: (1) through the general field staff of the agency; (2) through the staff of the medical assistance unit who are assigned to the 77 counties: 37 full-time "medical assistance unit workers" and 40 part-time (social work), with part-time service from the county administrator in each county; and (3) through the field staff of the Non-Technical Medical Care Unit, with supervision from the State office.</p>								
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Advisory Committee on Medical Care for Recipients of Public Assistance. It is composed of 20 members appointed by the State Public Welfare Commission. There are 6 ex officio members (President, Oklahoma State Medical Association; Executive Director, Oklahoma State Medical Association; President, Oklahoma State Osteopathic Association; Executive Director, Oklahoma State Osteopathic Association; Executive Director, Oklahoma Hospital Association; President, Oklahoma State Nursing Home Association). Authority for the Committee is administrative.</p>								
<b>4. Buy-In Agreement</b>	<p>State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money-payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.</p>								
<b>5. Claims Payment Process</b>	<table> <tr> <td data-bbox="52 1431 438 1576"> <b>a. State and Local Agencies</b> </td><td data-bbox="438 1431 1522 1576"> <p>Claims from all providers of medical care and services are processed and paid by the State Department of Institutions, Social and Rehabilitative Services.</p> </td></tr> <tr> <td data-bbox="52 1576 438 1632"> <b>b. Fiscal Agents</b> </td><td data-bbox="438 1576 1522 1632"> <p>None.</p> </td></tr> <tr> <td data-bbox="52 1632 438 1742"> <b>c. Prepaid Capitation Arrangements</b> </td><td data-bbox="438 1632 1522 1742"> <p>None.</p> </td></tr> <tr> <td data-bbox="52 1742 438 1852"> <b>d. Payments to Non-Medical Institutions</b> </td><td data-bbox="438 1742 1522 1852"> <p>None.</p> </td></tr> </table>	<b>a. State and Local Agencies</b>	<p>Claims from all providers of medical care and services are processed and paid by the State Department of Institutions, Social and Rehabilitative Services.</p>	<b>b. Fiscal Agents</b>	<p>None.</p>	<b>c. Prepaid Capitation Arrangements</b>	<p>None.</p>	<b>d. Payments to Non-Medical Institutions</b>	<p>None.</p>
<b>a. State and Local Agencies</b>	<p>Claims from all providers of medical care and services are processed and paid by the State Department of Institutions, Social and Rehabilitative Services.</p>								
<b>b. Fiscal Agents</b>	<p>None.</p>								
<b>c. Prepaid Capitation Arrangements</b>	<p>None.</p>								
<b>d. Payments to Non-Medical Institutions</b>	<p>None.</p>								



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**E. Financing**

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<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Oklahoma as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 68.84.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from revenue from State sales tax earmarked for public assistance and medical assistance programs.
<b>4. Deficit Financing</b>	There is no authority for deficit financing.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Public Welfare Division  
(in Office of the Governor)

January 1, 1970

OREGON

**A. General Information**

<b>1. Legal Base</b>	Oregon Revised Statutes, Sections 411.060, 411.070, 411.010(5), 414.025(4), and 414.065.
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1967. Original plan approved by the Federal agency on November 16, 1967.
<b>3. Administrative Responsibility</b>	<p>The Public Welfare Division (operating under the Office of the Governor) is the single State agency with responsibility for supervising the administration of the program by 36 county public welfare departments.</p> <p>(Pursuant to Section 225, Chapter 597, Oregon Laws 1969, effective 7/1/69, the Public Welfare Division succeeded to all duties, functions, and powers formerly vested in the State Public Welfare Department and the State Public Welfare Commission.)</p>
<b>4. Historical Background</b>	<p>Beginning in November 1956, a broad range of medical services for recipients in all Federally aided categories was provided on a Statewide basis through vendor payments to providers, with Federal financial participation in the costs of such care. Full implementation of the law was limited only by the availability of appropriated funds, which were used to provide "minimum adequate medical services".</p> <p>In November 1961, on the basis of newly enacted legislation, a Federal-State program of Medical Assistance for the Aged (MAA) was instituted providing medical care for persons age 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need. Services under the MAA program were less comprehensive than those provided for public assistance recipients.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only.
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all eligible individuals with the following exception:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older.</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. On written order of physician. Limited to 21 days per fiscal year, and to cases where payment for attending physician's services is authorized. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Public Welfare Division.
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older in State institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Public Welfare Division.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older in State institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Public Welfare Division.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. Prior authorization required for elective and rehabilitative procedures. Reimbursement on basis of reasonable cost. Claims processed and paid by State Public Welfare Division.
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Public Welfare Division.



**B. Medical and Remedial Care and Services (Continued)**

<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For persons of all ages. No limitations. No requirements for prior authorization. Reimbursement on basis of cost-related per diem rate established for each facility; payment up to maximum of \$9.60 per day. Claims processed and paid by State Public Welfare Division.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Not provided.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. Office visits limited to 4 in any 7 days; home visits limited to 3 in any 7 days; visits in hospital and elsewhere are unlimited. Prior authorization by Public Welfare Division required for elective and rehabilitative procedures, and for surgical procedures not listed in Physicians' Guide. Reimbursement on basis of fee schedule; reimbursement for medical services to hospital in-patients limited to maximum fee-per-day. Claims processed and paid by State Public Welfare Division.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>  <b>b. Optometrists</b>  <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Provided. No limitations, but subject to availability of miscellaneous medical funds. Prior authorization by county welfare department required. Reimbursement on basis of fee negotiated by county welfare department (related to prevailing rate in community), not to exceed established fee in State agency Guide to Physicians' Services. Claims processed and paid by State Public Welfare Division.</p> <p>Provided. Examinations and professional services. No limitations. No requirement for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Public Welfare Division.</p> <p>Provided. Examinations and treatment; also, laboratory and X-ray procedures as specified in fee schedule. Subject to availability of miscellaneous medical funds. Prior authorization by county welfare department required. For visits in excess of 4 per calendar month, and for laboratory and X-ray work in excess of \$12 per month, prior authorization by County Medical Consultant or State Medical Director is required. Reimbursement on basis of fee schedule. Claims processed and paid by State Public Welfare Division.</p> <p>Naturopaths. Services provided, subject to availability of miscellaneous medical funds. Examinations and treatment; also, laboratory and X-ray procedures as specified in fee schedule. Prior authorization by county welfare department required. For visits in excess of 4 per calendar month, and for laboratory and X-ray work in excess of \$12 per month, prior authorization by County Medical Consultant or State Medical Director is required. Reimbursement on basis of fee schedule. Claims processed and paid by State Public Welfare Division.</p>
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipients while at home, subject to availability of miscellaneous medical funds. Prior authorization by county welfare department required. Reimbursement on basis of fee schedule.</p> <p>(a) Intermittent or part-time nursing services. Provided.</p> <p>(b) [Services of home health aide. Not provided.]</p> <p>(c) Medical supplies, equipment, and appliances. Provided.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>9. Private Duty Nursing Services (RN or LPN)</b>	Provided. Subject to availability of miscellaneous medical funds. Limited to hospital inpatients; when ordered by a physician and approved by local medical consultant. Prior authorization by county welfare department required. Daily review required when care extends beyond 3 days. Reimbursement on basis of fee schedule. Claims processed and paid by State Public Welfare Division.
<b>10. Clinic Services (Other than Hospital)</b>	Provided. No limitations. Prior authorization by county welfare department required for elective and rehabilitative procedures. Reimbursement on basis of fee schedule; negotiated rate for non-schedule items. Claims processed and paid by State Public Welfare Division.
<b>11. Dental Services</b>	Provided. Subject to availability of dental funds. Limited to general dental services, dentures, and repair of dentures. Orthodontia not included. Prior authorization (including statement of maximum dollar amount authorized) by county public welfare department required. Reimbursement on basis of fee schedule. Claims processed and paid by State Public Welfare Division.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. Subject to availability of miscellaneous medical funds. Limited to cases where rehabilitation or restoration is possible. Prior authorization by local public welfare department required. Payment to all qualified vendors, including private practicing therapists. Claims processed and paid by State Public Welfare Division.
<b>b. Occupational Therapy</b>	Not provided.
<b>c. Speech Therapy</b>	Not provided.
<b>d. Audiology</b>	Not provided.
<b>13. Prescribed Drugs</b>	Provided. All items on Basic Drug List, plus "exception drugs" where clear therapeutic need not met by items on Basic Drug List. Prior authorization for "exception drugs" (including statement of period of time covered and quantity allowed) by State Public Welfare Division required. However, physician can obtain any drug needed on an emergency basis not to exceed 5-day supply. Reimbursement for scheduled items on basis of fee schedule; for non-scheduled items, whole-sale cost plus 50% plus 85¢ per prescription. Claims processed and paid by State Public Welfare Division.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. Subject to availability of miscellaneous medical funds. Must be recommended by examining ophthalmologist or optometrist. Prior authorization (including statement of maximum dollar amount authorized) by county public welfare department required. Reimbursement on basis of fee schedule. Claims processed and paid by State Public Welfare Division.
<b>b. Hearing Aids</b>	Provided. Subject to availability of miscellaneous medical funds. Prior authorization by State Public Welfare Division required. Reimbursement on basis of negotiated fee. Claims processed and paid by State Public Welfare Division.
<b>c. Dentures</b>	Provided. Subject to availability of dental funds. Prior authorization by county public welfare department required. Reimbursement on basis of fee schedule. Claims processed and paid by State Public Welfare Division.
<b>d. Other Prosthetic Devices</b>	Provided. Subject to availability of miscellaneous medical funds. Any prosthetic device ordered by a physician. Prior authorization by State Public Welfare Division required. Reimbursement on basis of negotiated fee. Claims processed and paid by State Public Welfare Division.
<b>15. Family Planning Services</b>	Provided. Under direction of physician; including drugs, supplies, and devices. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Public Welfare Division.
<b>16. Services of Christian Science Nurses</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Public Welfare Division.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. When necessary to prevent death or serious impairment to health. Limited to days necessary until earliest possible transfer to qualified hospital. No requirements for prior authorization. Reimbursement on basis of established rate. Claims processed and paid by State Public Welfare Division.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. Subject to medical need and, in some cases, to availability of funds. Any service ordered by physician, upon special authorization by State Public Welfare Division. Reimbursement on basis of negotiated fee. Claims processed and paid by State Public Welfare Division.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. Subject to availability of funds and based on medical need. Prior authorization by the Local Medical Consultant or, in his absence, the State Medical Director, required. Reimbursement on basis of negotiated fee. Claims processed and paid by State Public Welfare Division.
<b>b. Other</b>	Provided. Subject to availability of funds. Any appropriate means (e.g., bus, taxi, train, plane), including related travel expenses and cost of an attendant. No limitations. Prior authorization by county public welfare department required. Reimbursement on basis of negotiated rate. Claims processed and paid by State Public Welfare Division.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to medical assistance as early as the date of application or, in emergency situations (e.g., where earlier application could not be made because county office was closed for week-end or holiday), if application is made on the next work day and provided all conditions of eligibility were met on the day on which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or caretaker relative (as specified in the State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(3) Child in foster home or private institution. [Including non-AFDC foster care.]</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(6) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p>
<b>b. Age 21 to 64</b>	<p>(1) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.

**C. Eligibility for Medical Assistance (Continued)**

<p><b>3. Coverage of the Categorically Needy</b></p> <p><b>a. FFP Claimed in Medical and Administrative Costs</b></p> <p><b>b. FFP Claimed in Administrative Costs Only</b></p>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC program but who would be eligible for such assistance if they left the facility.</p> <p>(6) Children under age 21 in foster homes or private institutions under a purchase of care agreement for whom the Public Welfare Division is assuming financial responsibility in whole or in part.</p> <p>(7) Parents or caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(8) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p>None.</p>
<p><b>4. Coverage of the Medically Needy</b></p>	<p>Not included.</p>
<p><b>5. Financial Criteria</b></p> <p><b>a. For Categorically Needy Persons</b></p> <p><b>b. For Medically Needy Persons</b></p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>Not applicable.</p>
<p><b>6. Financial Responsibility of Relatives</b></p>	<p>The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children under age 21 and for children who are blind or permanently and totally disabled.</p>
<p><b>7. Identification to Vendors of Persons Eligible</b></p>	<p>A Medical Care Identification Card is issued monthly by the State Public Welfare Division to each case certified as eligible for medical assistance. Face of card carries name of recipient and of any other eligible members of the family and shows first and last day of period for which card is valid. For foster care cases, a "Foster Child Medical Care Identification Card" is issued which names both the eligible child and the foster parent.</p>



**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	Responsibility for over-all direction of the Medical Assistance Program is vested in the Medical Assistance Section (medical assistance unit), a large organizational segment located directly under the Administrator, State Public Welfare Division. Principal professional staff of the Division consists of a full-time Director (M.D.), an Assistant Director (social work), and a psychiatric social worker, supplemented by the part-time services of a pharmacist, a dentist, and a psychiatrist. Services of professional consultants are available as needed.
<b>2. Supervision of Statewide Operations</b>	Supervision of the locally administered program is maintained through the activities of 13 general field staff supervisors (social work), and 4 consultants (medical social work) responsible to the medical assistance unit, who are assigned to specific geographical areas.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Advisory Committee on Medical Assistance for the Under-Privileged. It is composed of 15 members appointed by the Governor and has in addition one ex officio member (Single State Agency Medical Director). Authority for the Committee is statutory (Chapter 502, Laws 1967, Oregon Regular Session).
<b>4. Buy-In Agreement</b>	None.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Public Welfare Division processes and pays all vendor claims for services provided under the program.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Oregon as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 56.35.
<b>2. State/Local Participation</b>	State funds are used to finance 100% of the non-Federal share of costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs are derived from State General Funds specifically appropriated for the Medical Assistance Program. Appropriations are made biennially; unobligated balance reverts at end of biennium.
<b>4. Deficit Financing</b>	State law prohibits deficit spending. When additional funds are needed before the next appropriation period, Emergency Board may approve transfer of funds from non-medical or emergency appropriation.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

PENNSYLVANIA

**A. General Information**

<b>1. Legal Base</b>	Article IV, Public Welfare Code: Public Assistance and Medical Assistance (Act 21 of June 13, 1967, as amended).
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1966. Original plan approved by the Federal agency on March 31, 1966.
<b>3. Administrative Responsibility</b>	The Department of Public Welfare serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices (67 county assistance offices), and a Central Bureau of Medical Assistance under the Office of Medical Services and Facilities.
<b>4. Historical Background</b>	<p>Provisions for vendor payment of medical care costs with Federal financial participation through the public assistance programs have been in effect since March 1956. The early program did not include hospital care because of the State system of public hospitals and "State aid" to non-profit, non-sectarian hospitals. All other services were available to all the categories; however, nursing home care was provided only through the money payment in the adult categories. In March 1964, the service of inpatient hospital care was extended to persons under the age of 65 who were recipients of APTD or AFDC. For blind recipients, the service was provided without Federal financial participation through a system of Purchased Hospital and Post-Hospital Care which included the persons under the Blind Pension program.</p> <p>In January 1965, the State began a Federal-State program of Medical Assistance for the Aged (MAA) for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. The services provided were inpatient hospital care, nursing home care, and post-hospital care in the home as a continuation of inpatient hospital care and provided under an approved "home-hospital" program. At the same time the medical services under the OAA program were amended to extend these same services to OAA recipients, except that nursing home care in non-public nursing homes continued to be paid within the money payment. These programs were discontinued when the title XIX program began.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Difference in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c., B.4.c.)</p> <p>Certain services provided for categorically needy persons are not made available to medically needy persons. (Items B.7.a., B.11., B.13., B.14.c., B.21.a.)</p> <p>Certain services provided for categorically needy persons are made available on a more limited basis to medically needy persons. (Item B.15.)</p> <p>Eyeglasses and services of optometrists are provided only for recipients of Aid to the Blind, school children, and persons with eye pathology. (Items B.7.b. and B.14.b.)</p>



**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Up to 60 days of intermittent or consecutive inpatient care in a benefit period (new benefit period begins when non-hospitalized for 60 consecutive days). Excludes admissions for diagnostic tests not necessary for diagnosis and treatment of the illness; diagnostic or therapeutic procedures primarily for experimentation, research, or educational purposes; rest cures; room and board for patients during child's hospitalization, and vice versa; plastic or cosmetic surgery for beautifying purposes. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed by fiscal agent (Capital Blue Cross or Inter-County Hospitalization Plan, Inc.); paid by State Department of Public Welfare.</p> <p>Not provided.</p> <p>Provided. Limited to persons age 65 or older in public and private institutions. Unlimited care for persons in public institutions; up to 60 days per benefit period for persons in private institutions. No requirements for prior authorization. Reimbursement to public institutions on basis of average per diem cost; to private institutions on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare, except private hospital claims processed by fiscal agent (Capital Blue Cross or Inter-County Hospitalization Plan, Inc.).</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided in hospital clinics. Unlimited. No requirements for prior authorization for persons covered by buy-in agreement; for others, prior authorization by State office required for visits for chronic conditions in excess of 3 per month considered in combination with calls in approved non-hospital clinic. Reimbursement on basis of fee schedule for visit and for diagnostic X-rays. Claims processed and paid by State Department of Public Welfare.</p> <p><i>Under special "Hospital-Home Care" program, all recipients are, upon discharge from inpatient hospital status, eligible for a continuation of hospital-type medical care and treatment for up to 180 uninterrupted days during a benefit period (day of discharge as an inpatient to day of next admission as an inpatient), if prescribed by attending physician and authorized by county office. Services are furnished to such outpatients by a hospital officially certified for participation in the "Hospital-Home Care" program; all of the hospital's facilities are made available, including physicians' services, nursing service, laboratory service, oxygen, medications, and sick room supplies. Reimbursement on basis of average daily cost to hospital for providing this type of care or \$5 per day, whichever is less. Claims processed and paid by fiscal agent (Capital Blue Cross or Inter-County Hospitalization Plan, Inc.); paid by State Department of Public Welfare.</i></p> <p><i>Partial hospitalization for psychiatric care—limited to 120 days in a consecutive 12-month period. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.</i></p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. Limited to studies listed in State fee schedule. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>	<p>Provided. For persons of all ages. Unlimited in public facilities (County Homes, Geriatrics Centers, Schools and Hospitals for the Mentally Retarded); in private facilities, limited to 60 days of post-hospital care in a 12-month period. No requirements for prior authorization. Reimbursement of private facilities on basis of fixed per diem fee; of public facilities on basis of average per diem cost. Claims processed and paid by State Department of Public Welfare.</p> <p>Not provided.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older who are patients in public or private institutions. Unlimited care in public institutions; up to 60 days per benefit period for persons in private institutions participating in program under agreement with State agency. No requirements for prior authorization. Reimbursement to public facilities on basis of average per diem cost; to private facilities on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. Subject to the following limitations: Payment for services rendered to a patient during hospitalization limited to \$200 during a hospital benefit period; no payment for physician's services rendered to patients in an outpatient hospital clinic or independent clinic, nor for laboratory tests performed in physician's office. No other limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims for services to hospital inpatients processed by fiscal agent (Pennsylvania Blue Shield), paid by State Department of Public Welfare. All other claims processed and paid by State Department of Public Welfare.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Limited to categorically needy persons for services prescribed by a physician. Routine foot care excluded. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.
<b>b. Optometrists</b>	Provided. Limited to recipients of Aid to the Blind, school children, and persons with eye pathology. Prior authorization from local office required. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.
<b>c. Chiropractors</b>	Provided. Payment for services rendered to patient during hospitalization limited to \$200. No payment for services rendered to patients in an outpatient hospital clinic or independent clinic, nor for laboratory tests performed in practitioner's office. No other limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. As furnished by a home health agency or visiting nurse association, subject to the following limitations (considered in combination with home health aide visits in (b), below): (1) For prenatal care, 1 visit per month, (2) for teaching home treatments, maximum of 3 visits, (3) visits for other reasons, limited after first 4 weeks to 12 per month. After first visit, services must be prescribed by a physician. Reimbursement on basis of fee schedule. Claims processed by fiscal agent (Capital Blue Cross or Inter-County Hospitalization Plan, Inc.); paid by State Department of Public Welfare.</p> <p>(b) Services of home health aide. Provided. As furnished by a home health agency. For persons age 65 or over covered by State's buy-in agreement, 100 visits per year (in combination with all other home health agency visits). For all persons these services are provided subject to the following limitations (considered in combination with home health agency nursing visits): (1) For prenatal care, 1 visit per month, (2) for teaching home treatments, maximum of 3 visits, (3) visits for other reasons, limited after first 4 weeks to 12 per month. After first visit, services must be prescribed by a physician. Reimbursement on basis of fee schedule. Claims processed by fiscal agent (Capital Blue Cross or Inter-County Hospitalization Plan, Inc.); paid by State Department of Public Welfare.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations. Prior authorization from local office required for purchases costing over \$10; from State office if cost exceeds \$50. Reimbursement on basis of State formulary or community price, whichever is lower. Claims processed and paid by State Department of Public Welfare.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital Clinics)</b>	Provided. Unlimited. No requirements for prior authorization for persons covered by buy-in agreement; for others, prior authorization by State office required for visits for chronic conditions in excess of 3 per month considered in combination with calls in approved non-hospital clinic. Reimbursement on basis of fee schedule for visit and for diagnostic X-rays. Claims processed and paid by State Department of Public Welfare.
<b>11. Dental Services</b>	Provided. Orthodontia not included. Provided only for categorically needy persons. (Except: Oral surgery necessitating hospitalization for cutting procedures is provided for all eligible persons.) Prior authorization from local office required for general anesthesia. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Not provided.
<b>b. Occupational Therapy</b>	Not provided.
<b>c. Speech Therapy</b>	Not provided.
<b>d. Audiology</b>	Not provided.
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs listed in State Drug Formulary. Provided for categorically needy persons only. Maximum 45-day supply per prescription (except, 80-day supply of anovulatory drugs). Prior authorization from local office required for vitamin preparations, anti-obesity drugs, and liver extracts, and for prescriptions costing over \$10; from State office if cost exceeds \$50. Reimbursement on basis of Drug Formulary cost plus 50% mark-up (25% for hospital pharmacies); compounded prescriptions on basis of cost of ingredients plus fixed fee of \$1.25; over-the-counter items on basis of Formulary or community price, whichever is less. Claims processed and paid by State Department of Public Welfare.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. Limited to school children and persons with eye pathology. Prior authorization from local office required. Reimbursement on basis of cost plus 10%, but not to exceed fixed maximum fee. Claims processed and paid by State Department of Public Welfare.
<b>b. Hearing Aids</b>	Not provided.  [However, for categorically needy persons, payment will be made for repair of hearing aids, with requirement for prior authorization by local office if cost exceeds \$10, or by State office if cost exceeds \$50.]
<b>c. Dentures</b>	Provided. For categorically needy persons only. No limitations. Prior authorization from local office required for dentures, or for resetting, relining, or rebasing dentures. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.
<b>d. Other Prosthetic Devices</b>	Provided. Artificial limbs and eyes, braces, orthopedic shoes, abdominal supports, and other devices. No limitations. Prior authorization from local office required if charges exceed \$10, or from State office if they exceed \$50. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.
<b>15. Family Planning Services</b>	Provided. Physician's services provided for all; drugs, supplies, and devices provided for categorically needy persons only. Anovulatory drugs limited to 80-day supply per prescription. Prior authorization from local office required if prescription exceeds \$10, or from State office if cost exceeds \$50. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.

**B. Medical and Remedial Care and Services (Continued)**

16. Services of Christian Science Nurses	Not provided.
17. Care and Services in Christian Science Sanatoria	Not provided.
18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)	Not provided.
19. Personal Care Services In Patient's Home	Not provided.
20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services	Not provided.
21. Transportation	
a. Ambulance	Provided. For categorically needy persons only. Provided only when no organization, such as police or hospital, is available which furnishes such service without charge. Maximum payment of \$75 per service. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Welfare.
b. Other	Not provided.  [For public assistance recipients, an amount may be budgeted as a special needs item for inclusion in the assistance payment.]

**C. Eligibility for Medical Assistance**

1. Date of Entitlement	Upon determination of eligibility an individual is retroactively entitled to assistance as early as 30 days prior to date of application, provided all conditions of eligibility were met in the month in which services were rendered.
2. Conditions of Eligibility (By Age Groups)	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
a. Under Age 21	(1) Individual under age 21.
b. Age 21 to 64	(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.  (2) Person who is blind (State definition).  (3) Person who is permanently and totally disabled (State definition).  (4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.
c. Age 65 or older	(1) Individual who has attained age 65.





**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p>(1) <i>Income</i></p> <p>Annual income which may be retained for basic maintenance needs: \$2000 for one person, \$2500 for family of 2, \$3250 for 3, \$4000 for 4, plus \$750 for each additional member of the family unit.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$2000 annual income for the first 6 consecutive months; thereafter, \$15 per month for personal care items, with all other income considered available to meet the cost of care.</p> <p>(2) <i>Resources</i></p> <p>Home used as a residence is exempt regardless of value. Income-producing non-resident real property may also be retained, provided its value is reasonably related to the income produced.</p> <p>The following personal property is exempt regardless of value: Household furnishings, clothing, personal effects, an automobile, and life insurance with cash surrender value not exceeding \$500.</p> <p>Other real and personal property (including cash surrender value of life insurance in excess of \$500) may be retained up to a combined value of \$2400 for one person, or \$3840 for 2 or more persons; except that, for person remaining in long-term care in a medical facility longer than 6 months, combined value may not exceed \$1500.</p> <p>Resources in excess of these amounts do not disqualify applicant from receiving medical assistance under the program; excess is applied to costs of care.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>A Medical Identification Card is issued quarterly to each single and multiple case certified as eligible. A white card is issued to those who are categorically needy; a green card to those who are medically needy; an orange card to State Blind Pension recipients who do not qualify as medically needy. Card covering a multiple case is issued in the name of a responsible adult member; the names of eligible members in the family group are not listed on the card but provided to the adult member in a separate document. The face of the card carries the case number, county code number, date of expiration, and listing of services not covered. The reverse of the card gives instructions for its use and the penalties for misuse.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Bureau of Medical Assistance is headed by a Medical Assistance Administrator who is responsible to the Commissioner of Medical Services and Facilities. The staff includes a Chief Medical Consultant, Utilization Review Director, Casework Supervisor, a Dental Consultant (part-time), three Nurse Consultants, two Pharmacists, two Policy Specialists, two Review Physicians (full-time) and two Review Physicians (part-time), four Field Representatives, and other administrative and clerical staff.</p>
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of Statewide operations is accomplished through six DPW Regional Offices with technical and medical direction from the Bureau of Medical Assistance of the Office of Medical Services and Facilities. Most of the County Assistance Offices employ part-time medical and dental consultants and the larger County Offices usually have a full-time physician as well as professional consultants.</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Medical Assistance Advisory Council. It is composed of 16 members appointed by the Secretary of Public Welfare and has in addition five ex officio members: Secretary of Public Welfare, Deputy Secretary of Mental Health, Commissioner of Family Services of the Department of Public Welfare, Commissioner of Medical Services and Facilities, and Medical Assistance Administrator, all from the Department of Public Welfare. Authority for the Council is administrative.</p>



**D. Administration and Management (Continued)**

<b>4. Buy-in Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	Claims from all providers are paid by the State agency; claims from all except those identified in sub-item <i>b.</i> below are processed by the State agency as well as paid by it.
<b>b. Fiscal Agents</b>	<p>The State agency uses three fiscal agents to process claims from specified providers of services but pays all vendor claims itself. The fiscal agents are:</p> <ol style="list-style-type: none"> <li>1. Inter-County Hospitalization Plan, Inc.—to process claims from hospitals and home health agencies in part of the southeast area of State.</li> <li>2. Capital Blue Cross—to process claims from hospitals and home health agencies throughout remainder of State.</li> <li>3. Pennsylvania Blue Shield—to process claims for all physicians' services provided to hospital inpatients.</li> </ol>
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Pennsylvania as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 54.60.
<b>2. State/Local Participation</b>	County funds are used to pay 100% of the non-Federal share of expenditures for nursing home care in county-operated nursing homes. State funds are used to pay 100% of the non-Federal share of all remaining program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually from State General Fund. Unobligated balance reverts to the General Fund at the end of each fiscal year.
<b>4. Deficit Financing</b>	If additional funds are needed for the Medical Assistance program before the next appropriation period, a request is addressed to the Governor, who may either authorize the transfer of funds budgeted for another segment of the Department of Public Welfare or seek an additional appropriation from the General Assembly.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health

January 1, 1970

PUERTO RICO

**A. General Information**

<b>1. Legal Base</b>	The Commonwealth's authority for the program is based on: Organic Act of 1917, Sec. 13; Constitution of Commonwealth of Puerto Rico, 1952, Art. IV, Sec. 5 and 6; Act No. 95 of May 12, 1943, as amended by Act No. 106 of May 7, 1948; Title VIII, ch. 1, Sec. 8-11, Laws of Puerto Rico annotated.
<b>2. Beginning Dates</b>	Program went into operation on January 1, 1966. Original plan approved by the Federal agency on March 31, 1966.
<b>3. Administrative Responsibility</b>	<p>The Department of Health serves as the single State agency with responsibility for administering the program on a State-wide basis through a system of local health offices.</p> <p>The determination of eligibility for medical assistance is made by Technicians of the Department of Social Services under the supervision of Social Workers at the medical installations of the 76 municipalities.</p>
<b>4. Historical Background</b>	<p>As early as 1912 the Commonwealth government assumed responsibility for public health services; and by 1935 it had established an Island-wide system of public health units. Beginning in 1948, the need for medical care was met through modern health centers and health facilities supported by Federal, State, and Municipal funds.</p> <p>Although the Federal-State public assistance programs began in October 1950, when Federal financial participation in vendor payments was also authorized, there was no incentive for having the Division of Public Welfare (then a part of the Department of Health) make payments for medical care because of certain statutory limitations on the amount of total Federal funds for public welfare. When the 1958 amendments to these Federal provisions made such payments financially feasible, the Commonwealth began using vendor payments for medical services provided to recipients of OAA, effective October 1, 1960. At the same time a program of Medical Assistance for the Aged (MAA, a Federal-State program) was begun for persons aged 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. The only services provided were inpatient hospital care and out-patient hospital and dispensary services. Medicines prescribed while a patient was hospitalized were paid for; and for OAA recipients, dental services which were provided as a part of inpatient hospital care were paid for. In both the OAA and the MAA program, payments were made to the Department of Health on the basis of the average cost per patient-day.</p> <p>In October 1963, when the Commonwealth had elected the two-category system of Aid to the Aged, Blind, and Disabled (AABD) and Aid to Families with Dependent Children, the same scope of services formerly available only to OAA recipients was made available to all recipients of AABD. No vendor payments were made for medical services in behalf of recipients of AFDC. These programs continued until the beginning of the medical assistance program under title XIX.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis are provided only for patients who are 65 years of age or older. (Items B.1.b. and B.4.b.)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p>



## B. Medical and Remedial Care and Services

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to services provided in publicly operated hospitals. No other limitations. No requirements for prior authorization. Cost of operating facilities financed through appropriated funds.</p> <p>Provided. Limited to patients age 65 or older in publicly operated institutions for tuberculosis. No limitations. No requirements for prior authorization. Cost of operating facilities financed through appropriated funds.</p> <p>Not provided.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. Limited to services provided in publicly operated medical facilities. No other limitations. No requirements for prior authorization. Cost of operating facilities financed through appropriated funds.</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. Limited to services provided in publicly operated medical facilities. No other limitations. No requirements for prior authorization. Cost of operating facilities financed through appropriated funds.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to persons age 21 or older, and to services provided in publicly operated medical facilities. No other limitations. No requirements for prior authorization. Cost of operating facilities financed through appropriated funds.</p> <p>Provided. Limited to patients age 65 or older in publicly operated institutions for tuberculosis. No other limitations. No requirements for prior authorization. Cost of operating facilities financed through appropriated funds.</p> <p>Not provided.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Provided. As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. Limited to services of salaried physicians employed in publicly operated medical facilities. No other limitations. No requirements for prior authorization. Included in cost of operating facilities which are financed through appropriated funds.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>  <b>b. Optometrists</b>  <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Not provided.</p> <p>Not provided.</p> <p>Not provided.</p> <p>Not provided.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) [Intermittent or part-time nursing service. Not provided.]</p> <p>(b) [Services of Home Health Aide. Not provided.]</p> <p>(c) [Medical supplies, equipment, and appliances. Not provided.]</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p> <p>[Payments are not made to private-practicing RN's or LPN's, but full-time nursing service is available to inpatients of publicly operated hospitals when medically needed.]</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. Limited to services provided through public health units and publicly operated health centers. No other limitations. No requirements for prior authorization. Included in cost of operating facilities financed through appropriated funds.</p>
<b>11. Dental Services</b>	<p>Provided. Limited to dental services provided in publicly operated medical facilities. No other limitations. No requirements for prior authorization. Cost of operating facilities financed through appropriated funds.</p>
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	<p>Provided. Limited to services provided in certain publicly operated rehabilitation centers. No other limitations. No requirements for prior authorization. Cost of operating facilities financed through appropriated funds.</p>
<b>b. Occupational Therapy</b>	<p>Provided. Limited to services provided in certain publicly operated rehabilitation centers. No other limitations. No requirements for prior authorization. Cost of operating facilities financed through appropriated funds.</p>
<b>c. Speech Therapy</b>	<p>Not provided.</p>
<b>d. Audiology</b>	<p>Not provided.</p>
<b>13. Prescribed Drugs</b>	<p>Provided. Legend and non-legend drugs. Limited to drugs dispensed to patients through pharmacies of publicly operated hospitals, health centers, and similar health facilities. No other limitations. No requirements for prior authorization. Drugs purchased centrally by competitive bid; financed through appropriated funds used to meet cost of operating the facilities.</p>
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	<p>Not provided.</p>
<b>b. Hearing Aids</b>	<p>Not provided.</p>
<b>c. Dentures</b>	<p>Not provided.</p>
<b>d. Other Prosthetic Devices</b>	<p>Not provided.</p>
<b>15. Family Planning Services</b>	<p>Provided. Limited to services provided by pharmacies and salaried personnel of publicly operated medical facilities. No other limitations. No requirements for prior authorization. Included in operational costs of facilities which are financed through appropriated funds.</p>
<b>16. Services of Christian Science Nurses</b>	<p>Not provided.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Limited to services provided in publicly operated hospitals. No other limitations. No requirements for prior authorization. Included in cost of operating facilities which are financed through appropriated funds.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. Limited to diagnostic and preventive services provided through public health units and publicly operated health centers. No other limitations. No requirements for prior authorization. Cost of operating facilities financed through appropriated funds.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. Limited to ambulance service provided by publicly operated hospitals. No other limitations. No requirements for prior authorization. Financed through appropriated funds used to meet cost of operating the facilities.
<b>b. Other</b>	Provided. Limited to transportation of patients in automobiles and other means of public transportation. No other limitations. No requirements for prior authorization. Financed through appropriated funds used to meet cost of operating the facilities.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as three months prior to the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a:
<b>a. Under Age 21</b>	(1) Individual under age 21.
<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of AABD.</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.

**C. Eligibility for Medical Assistance (Continued)**

<b>3. Coverage of the Categorically Needy</b>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p>
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <ul style="list-style-type: none"> <li>(1) Recipients of AABD and AFDC</li> <li>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</li> <li>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</li> </ul> <p style="text-align: center;"><i>Optional</i></p> <ul style="list-style-type: none"> <li>(4) Persons eligible for but not receiving AABD or AFDC.</li> <li>(5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC programs but who would be eligible for such assistance if they left the facility.</li> <li>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</li> <li>(7) All individuals under age 21.</li> <li>(8) Essential spouse [title XIX definition] of a recipient of AABD. (Categorically needy only.)</li> </ul>
<b>b. FFP Claimed in Administrative Costs Only</b>	<p style="text-align: center;"><i>Optional</i></p> <ul style="list-style-type: none"> <li>(1) Unattached individuals age 21 to 64 who do not meet criteria of blindness or permanent and total disability.</li> <li>(2) Married couples under age 65 who are without children and who do not meet criteria of blindness or permanent and total disability.</li> <li>(3) Families with children under age 21 who do not meet AFDC criteria.</li> </ul>
<b>4. Coverage of the Medically Needy</b>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Items C.3.a. and b., above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.</p>
<b>5. Financial Criteria</b>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p>
<b>a. For Categorically Needy Persons</b>	<p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>



**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p>(1) <i>Income</i> Annual income which may be retained for basic maintenance needs: \$1500 for one person, \$1800 for family of 2, \$2200 for 3, \$2600 for 4, and \$400 for each additional family member living in the family group.</p> <p>(2) <i>Resources</i> A homestead is exempt regardless of value or equity.</p> <p>Other real property, if income-producing, may be retained up to a value of \$10,000.</p> <p>The following personal property is exempt regardless of value: Clothing and personal effects; household furnishings and appliances; an automobile if needed for transportation; personal property used to produce income or in connection with employment; home produce from garden, livestock, and poultry used for family consumption.</p> <p>Life insurance up to a cash surrender value of \$3000 per family may be retained.</p> <p>A reserve of other liquid and non-liquid assets (cash, stocks, bonds, excess life insurance, non-homestead non-income-producing real property, and excess value of income-producing real property) is allowed up to \$500 per unattached person living alone, plus \$100 for each additional member of the family unit living together. An additional \$500 may be retained if it is being reserved for a business venture or for buying or renting a home.</p> <p>Resources in excess of these amounts render an individual ineligible.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 and for adult unmarried children who are blind or permanently and totally disabled.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>A Medical Assistance Identification Card is issued by the Department of Health to each individual and family certified by the Social Services Technician. Card lists the name and medical identification code number of each eligible member of the family unit. Card is valid for one year, after which a redetermination of eligibility is required. Changes in the family unit composition and/or in income and resources during the year also require a redetermination of eligibility.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Director for the Medical Assistance Program (Master in Hospital Administration) is responsible to the Secretary of Health through the Assistant Secretary for Administration. The other professional staff of the unit consists of an Assistant Director (M.P.Ad.), Social Services Coordinator (MSW), Fiscal Executive (B.B.A.), Executive for Organization and Methods (B.B.A.) and a Statistician (B.B.A.). The unit also has the part-time service of a physician (M.D.) who is in the Bureau of Health.</p>
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of medical and eligibility aspects of Statewide operations is accomplished through staff located in 5 Health Regions; in each there are a Social Worker (MSW) full-time, a Medical Director (M.D.) part-time, and a Regional Supervisor (B.A.) full-time. In addition, these regions are served by 20 social workers (B.S.W.).</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Medical Assistance Advisory Committee. It is composed of 15 members appointed by the Governor. There is one ex officio member (Secretary of Health). Authority for the Committee is administrative.</p>
<b>4. Buy-In Agreement</b>	<p>None.</p>

**D. Administration and Management (Continued)**

<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	Services are provided in publicly operated medical facilities, including municipal facilities under contract to the Department of Health. Claims for Federal financial participation are based on an all-inclusive average rate for each medical facility.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Puerto Rico as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50%.
<b>2. State/Local Participation</b>	Of the non-Federal share of costs of the program, State funds are used to pay 67% of costs of medical assistance and local funds to pay 33%; for costs of administration, State funds are used for 95% of the costs and local funds for 5%.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually for a specific amount for title XIX program within the general budget.
<b>4. Deficit Financing</b>	There is no need for authority for deficit financing because the Commonwealth fiscal system operates in such a way that, if there is a deficit in one of the programs, funds can be transferred from other programs upon approval of the Governor.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Social Welfare

January 1, 1970

RHODE ISLAND

## A. General Information

1. Legal Base	Title 40, Chapter 10.1, General Laws of Rhode Island (Codification of Chapter 266, 1966 regular session of the Rhode Island General Assembly, approved May 26, 1966, which provided basic authority for the State's Medical Assistance Program).
2. Beginning Dates	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on October 7, 1966.
3. Administrative Responsibility	The Department of Social Welfare serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of 11 district offices.
4. Historical Background	<p>Provisions for payment of the costs of medical care by vendor payments under the Federal-State public assistance programs have been in effect since July 1, 1952, in all four categories. Until late in 1964, the State used a "pooled fund" into which per capita payments were made each month for recipients of public assistance money payments. The scope of services provided was comprehensive except that nursing home care was provided within the money payment for maintenance.</p> <p>In October 1964, the State began a Federal-State program of Medical Assistance for the Aged for persons age 65 and older who were not recipients of public assistance but who met certain criteria of medical and financial need. To help to finance the program, the enabling legislation, which was enacted in April 1964, created a "Medical Care Fund" consisting of employees' contributions of 1/2 of 1% of wages paid by employers (or earnings from self-employment) up to \$4800 in any calendar year, "except that an employee adhering to a faith depending on spiritual healing is exempt from these provisions." A full scope of services was provided, including post-hospital nursing home care.</p>
5. Scope of Coverage	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3 and C.4)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.c. and B.4.c.)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services provided for categorically needy persons are not made available to medically needy persons. (Items B.5.; B.7.a. and b.; B.14.a. and b.; B.21.a.)</p> <p>Certain services provided for categorically needy persons are made available on a more limited basis to medically needy persons. (Items B.2. and B.4.a.; B.14.d.)</p>

## B. Medical and Remedial Care and Services

1. Inpatient Hospital Services	
a. In General Hospitals	<p>Provided. No limitations. Prior authorization by State office required for stay in excess of 15 days per admission for persons under age 65, or in excess of 60 days for persons age 65 or older. Reimbursement on basis of reasonable cost. Claims approved and processed for payment by State Department of Social Welfare.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to patients age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims approved and processed for payment by the State Department of Social Welfare.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to patients age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims approved and processed for payment by State Department of Social Welfare.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations for the categorically needy. For medically needy persons, limited to diagnostic and therapeutic X-rays, pharmacy, and laboratory tests. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims approved and processed for payment by State Department of Social Welfare.
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims approved and processed for payment by State Department of Social Welfare.
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. Limited to persons age 21 or older. Unlimited services for categorically needy persons. For medically needy persons, limited to 90 days per admission. Prior authorization by State office required. Reimbursement on basis of reasonable cost, up to maximum of \$13 per diem. Claims processed and paid by State Department of Social Welfare.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare. Limited to categorically needy persons only.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. Limited up to 2 visits per month for a chronic illness and up to 8 visits per month for an acute illness with prior authorization required for additional visits. Limited to daily inpatient hospital visits per spell of illness up to 37 days. Inpatient hospital visits in excess of 37 and up to a maximum of 100 visits may be granted by prior authorization. Reimbursement for physicians services is based on the Blue Shield of Rhode Island Plan B for all surgical and diagnostic services effective 7/1/68 and a negotiated fee schedule established 1/1/67 for home, office, inpatient hospital visits, and nursing home visits. Claims approved and processed for payment by State Department of Social Welfare.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. For categorically needy persons only. Limited to an office visit at a fixed fee. Service may range from routine office visit to more extensive foot care depending on need or discretion of podiatrist. No requirements for prior authorization except for X-rays. Reimbursement on the basis of 11/1/66 negotiated fee schedule for podiatry services. Claims approved and processed for payment by the State Department of Social Welfare.
<b>b. Optometrists</b>	Provided. For categorically needy persons only. Prior authorization required for examination when a period of less than 2 years has elapsed since the last examination for recipients under 65 years of age, and less than 1 year for recipients over 65 years of age. Prior authorization also required for perceptual visual training. Reimbursement on basis of 7/1/66 negotiated fee schedule for optometric services. Claims approved and processed for payment by the State Department of Social Welfare.



**B. Medical and Remedial Care and Services (Continued)**

c. Chiropractors	Not provided.
d. Other	Not provided.
8. Home Health Care Services	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. As furnished by certified home health agency. Prior authorization required for visits in excess of 6 per month and limited to a maximum of 15 visits per month. Reimbursement on the basis of reasonable cost as listed and approved under the provisions of Title XVIII up to a maximum allowance of \$6 per visit. Claims approved and processed by the State Department of Social Welfare.</p> <p>(b) Services of home health aide. Not provided.</p> <p>(c) Medical supplies, equipment, and appliances. Not provided except as they may be included as prosthetic devices; see Item B.14.d. below.</p>
9. Private Duty Nursing Services (RN or LPN)	Not provided.
10. Clinic Services (Other than Hospital)	Not provided.
11. Dental Services	<p>Provided. Including orthodontia. Oral surgical procedures limited to those listed in Dental Fee Schedule. Prior authorization required for all procedures except (1) emergency and palliative treatment, and (2) examination and charting (new patients only), prophylaxis, and X-rays. Reimbursement on basis of 10/1/67 negotiated Dental Fee Schedule. Claims approved and processed by State Department of Social Welfare.</p>
12. Physical Therapy and Related Services	
a. Physical Therapy	<p>Provided. Limited to categorically needy persons only and when provided as an Outpatient Department Clinic visit. Claims approved and processed by State Department of Social Welfare.</p>
b. Occupational Therapy	Not provided.
c. Speech Therapy	<p>Provided. Limited to categorically needy persons only and when provided as part of an Outpatient Department Clinic visit. Claims approved and processed by State Department of Social Welfare.</p>
d. Audiology	<p>Provided. Limited to categorically needy persons only and when provided as part of an Outpatient Department Clinic visit. Claims approved and processed by State Department of Social Welfare.</p>
13. Prescribed Drugs	<p>Provided. Legend and non-legend drugs, upon written prescription of physician. No payment for drugs dispensed by physician. Prior written authorization by State office required for central nervous system stimulants, appetite depressants, injectibles (except insulin and adrenalin which are self-administered), and certain expensive drugs or drugs not within the scope of the drug program. Authorization not required for drugs dispensed on emergency basis to cover requirement for period of 72 hours. Original prescription not to exceed 30-day supply of any drug. Refills (not to exceed 3 within 90-day period after date original prescription was filled) allowed for certain drugs used for continuous treatment of chronic conditions. For recipient residing in own home: reimbursement for legend drugs on basis of cost plus professional fee of \$1.50 for each prescription or refill; for non-legend items, reimbursement on basis of standard over-the-counter price or cost plus \$1.50 professional fee, whichever is less. For recipient residing in skilled nursing home or Intermediate Care Facility: reimbursement for legend and non-legend drugs is on same basis as above except that the Special Professional Fee is \$1.10. (No extra payment in either situation for containers or compounding fees.) Claims approved and processed for payment by the State Department of Social Welfare.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>	
a. Eyeglasses	<p>Provided. For categorically needy persons only. Prior authorization required for lenses other than corrected curve single vision lenses, Kryptok bifocal lenses, cataract corrected curve single vision lenses, and clinical cataract bifocal lenses. Payment in accordance with actual laboratory costs as listed in certain optical company price lists books. Maximum fee allowed \$3.25. Request for payment must show the name or number of the frame and manufacturer plus the actual cost. All more expensive frames require prior authorization. Reimbursement on basis of 7/1/66 negotiated fee schedule. Claims approved and processed for payment by the State Department of Social Welfare.</p>
b. Hearing Aids	<p>Provided. For categorically needy person only. Including purchase and repair of hearing aid, but excluding batteries and other maintenance items. Prior authorization by State office required. Reimbursement on basis of fee schedule. Claims processed and approved for payment by State Department of Social Welfare.</p> <p>[A regular budgeted amount for batteries and other maintenance costs of hearing aid may be included in the monthly assistance payment of a recipient of AABD or AFDC.]</p>
c. Dentures	<p>Provided. Full and partial dentures. No specific limitations. Prior authorization by State office required. Reimbursement on basis of 10/1/67 Dental Fee Schedule. Claims processed and approved for payment by State Department of Social Welfare.</p>
d. Other Prosthetic Devices	<p>Provided. Surgical appliances and prosthetic devices by purchase or rental as ordered by physician, but for medically needy limited to relatively expensive items (excluding elastic stockings, trusses, and corsets.) Prior authorization by State office required for all items. Reimbursement for medical supplies on basis of community prices; of durable equipment and appliances on basis of reasonable charge negotiated between State office and vendor. Claims approved and processed for payment by State Department of Social Welfare.</p> <p>[Up to \$10 a month may be included as a special need item in the monthly assistance payment of a recipient of AABD or AFDC for purchase or repair of orthopedic shoes recommended by a medical authority.]</p>
15. Family Planning Services	<p>Provided. Including supplies, devices, and appliances. Prior written authorization by State office for items not covered by State drug formulary. Reimbursement to physician on basis of Physicians' Fee Schedule; to pharmacist on basis of cost plus professional fee or (for non-legend items) standard over-the-counter price, if less. Claims processed and approved for payment by State Department of Social Welfare.</p>
16. Services of Christian Science Nurses	Not provided.
17. Care and Services in Christian Science Sanatoria	Not provided.
18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)	Not provided.
19. Personal Care Services In Patient's Home	Not provided.
20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. For categorically needy persons only. When medically necessary. No requirements for prior authorization. Reimbursement on basis of 11/1/66 negotiated fee schedule. Claims approved and processed by State Department of Social Welfare.
<b>b. Other</b>	Not provided. [For recipients of AABD and AFDC who have need for transportation to reach medical and therapeutic facilities, an amount for public transportation (actual cost up to \$6 per month, or more if there is evidence of need) may be included in the monthly assistance payment.]

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to inpatient hospital services and physician's services while in hospital as early as three months prior to application, and for all other medical services provided under the program as early as the first day of the month of application, provided all conditions of eligibility were met in the month in which the services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Child in foster home or private institution for whom a public agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</p> <p>(3) Child placed in a foster home or private institution by a private non-profit agency.</p> <p>(4) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(5) Person who is blind (State definition).</p> <p>(6) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of AABD.</p>
<b>b. Age 21 to 64</b>	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of AABD.</p>
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.

### C. Eligibility for Medical Assistance (Continued)

<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of AABD and AFDC.</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving AABD or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(7) All children under age 21 in foster homes or private institutions for whom public agencies are assuming financial responsibility in whole or in part.</p> <p>(8) All children under age 21 in foster care placed by private non-profit agencies.</p> <p>(9) Essential spouse [title XIX definition] of a recipient of AABD. (Categorically needy only)</p>
<b>b. FFP Claimed in Administrative Costs Only</b>	<p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
<b>4. Coverage of the Medically Needy</b>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a., above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided for such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess, in accordance with regulations.</p>
<b>5. Financial Criteria</b>  <b>a. For Categorically Needy Persons</b>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>



**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p><b>(1) Income</b></p> <p>Annual income which may be retained for basic maintenance needs: \$2500 for one person, \$3500 for family of 2, \$3900 for 3, \$4300 for 4, and \$400 for each additional member of the family household.</p> <p><b>(2) Resources</b></p> <p>Real property used as a home is exempt regardless of value.</p> <p>The following personal property is exempt regardless of value: Household furnishings and personal effects.</p> <p>Life insurance may be retained up to face value of \$4000 for each aged, blind, or disabled adult, and for each parent in a family case, plus \$1000 for each dependent child under age 21.</p> <p>Tangible personal property, including an automobile, may be retained up to a value of \$5000 per household unit.</p> <p>Other personal property (including cash, savings, stocks and bonds) and non-home real property (whether income-producing or non-income-producing) may be retained up to value of \$4000 for one person, \$6000 for 2 persons, and \$100 for each additional person.</p> <p>Ownership of resources in excess of exempt or allowable amounts does not preclude eligibility but is applied against the costs of medical care.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>A check stub attached to the public assistance check is used by money payment recipients as the identification of eligibility for the month of issuance. For persons certified for medical assistance only, an eligibility identification card is issued by the State agency which shows the eligibility period and expiration date, at which time reapplication and recertification is required. Check stub and identification card show medical assistance number and name of recipient or head of family household, but do not list the names of other eligible family members. In addition, the State agency issues a plastic identification card which is used by vendors as an imprinting device for billing purposes.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Director of Medical Care Unit (the medical assistance unit) is a physician and is responsible to the assistant Director of Community Services. The full-time professional staff consists of a Chief Medical Care Specialist, 3 Senior Medical Care Specialists, 3 Medical Care Specialists (persons in all three kinds of positions are qualified in social work, medical care administration, and/or public administration), a Medical Care Program Pharmacist, and a Senior Pharmacist. In addition there are the following part-time staff: 3 Physician Consultants (M.D.), 6 Dental Consultants, 1 Orthodontic Consultant, and 2 Optometric Consultants.</p>
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of Statewide operations is accomplished through the regular field staff of the agency.</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Advisory Committee to the Rhode Island Medical Assistance Program. It is composed of 25 members appointed by the Director of the Department of Social Welfare. There is one ex officio member (State Director of the Child Health Division). Authority for the Committee is administrative.</p>

**D. Administration and Management (Continued)**

<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Social Welfare processes and approves for payment claims from providers of all the kinds of medical and remedial care and services encompassed in the plan.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Rhode Island as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 51.70.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually from the general funds of the State. Unobligated balance may be carried over at the end of the fiscal year.
<b>4. Deficit Financing</b>	There is no statutory prohibition against deficit financing. If annual appropriation is insufficient to meet costs of program operation, a deficiency appropriation can be obtained. Chapter 266, enacted by the 1966 Regular Session of the Rhode Island legislature, which authorized the State Medical Assistance program, provides in part that "the general assembly shall annually appropriate such sum as it may deem necessary to carry out the purposes of this chapter and the state comptroller is hereby authorized and directed to draw his orders upon the general treasurer for the payment of such sum or sums or so much thereof as may be required from time to time, upon the receipt by him of properly authenticated vouchers."



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

SOUTH CAROLINA

**A. General Information**

<b>1. Legal Base</b>	Code of Laws of South Carolina, 1962, as amended, Title 71, Chapter 1, Articles 1 through 8, and Chapter 4.
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1968. Original plan approved by the Federal agency on March 25, 1968.
<b>3. Administrative Responsibility</b>	The State Department of Public Welfare serves as the single State agency with responsibility for supervising the administration of the program on a Statewide basis through a system of local offices (46 county Departments of Public Welfare).
<b>4. Historical Background</b>	<p>The public assistance statute of South Carolina recognized medical care as assistance along with maintenance, but such care was provided only through the limited money payment to the individual recipient until a 1959 amendment authorized vendor payments for inpatient hospital care and post-hospital nursing home care under all public assistance categories. The provisions were effective July 1, 1959. All other kinds of care continued under the money payment, except that in 1964 long-term nursing home care for recipients of OAA, AB, and APTD was added to the scope of the vendor payment program.</p> <p>From July 1961 through June 30, 1968, the State had in operation a Federal-State program of Medical Assistance for the Aged (MAA), i.e., for persons aged 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need. This program also had a minimal scope of services and, during the final two years, was phased out to relate to the title XVIII program and prepare for title XIX program.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B.7.a., B.12.a., b., c.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	<p>Provided. Limited to 40 days per fiscal year for persons less than 65 years of age or over age 65 but not covered under title XVIII Part A (Medicare). No other limitation. No requirement for prior authorization, but admitting institution obligated to verify, through local office, the number of remaining hospital days available to the recipient. Reimbursement on basis of reasonable cost. For persons less than 65 years of age, claims processed and paid by State Department of Public Welfare; for persons 65 years of age and over, claims processed by fiscal agent (Blue Cross and Blue Shield of South Carolina) and paid by State Department of Public Welfare.</p>
<b>b. In Institutions for Tuberculosis</b>	<p>Provided. Limited to persons age 65 or older in the State Park Health Center (tuberculosis sanatorium). No other limitations. County Department of Public Welfare must furnish authorization to State office before payments can be made. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older in State institutions for mental diseases. No other limitations. Prior authorization required from county office. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims for services provided to persons age 65 or older processed by fiscal agent (Blue Cross and Blue Shield of South Carolina); and paid by State Department of Public Welfare. Claims for services provided to other recipients processed and paid by State Department of Public Welfare.
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims for services provided to persons age 65 or older processed by fiscal agent (Blue Cross and Blue Shield of South Carolina); for services provided to persons under age 65, processed by fiscal agent (Travelers Insurance Co.); payment made by State Department of Public Welfare.
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No limitations. Prior authorization required from the State agency. Reimbursement on basis of reasonable cost (determined according to Medicare principles for payments to Extended Care Facilities). Claims processed and paid by State Department of Public Welfare.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charge. Claims for services provided to persons age 65 or older processed by fiscal agent (Blue Cross and Blue Shield of South Carolina); for services provided to persons under age 65, processed by fiscal agent (Travelers Insurance Co.). Claims paid by State Department of Public Welfare.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Limited to persons age 65 or older covered by the State's buy-in agreement. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed by fiscal agent (Blue Cross and Blue Shield of South Carolina); paid by State Department of Public Welfare.
<b>b. Optometrists</b>	Provided. Limited to examinations, and to eyeglasses prescribed by ophthalmologist for post-operative need (glaucoma, cataracts). No requirements for prior authorization. Reimbursement on basis of usual and customary fee. Claims for services provided to persons age 65 or older processed by fiscal agent (Blue Cross and Blue Shield of South Carolina); for services provided to persons under age 65, processed by fiscal agent (Travelers Insurance Co.). Claims paid by State Department of Public Welfare.
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. If furnished by a home health agency. Limited to 100 visits per year (within overall limit of 100 visits from a home health agency per year). No requirements for prior authorization. Reimbursement on basis of reasonable cost (payment basis used by Social Security Administration for Medicare). Claims processed and paid by State Department of Public Welfare.</p> <p>(b) Services of home health aide. Provided. If furnished by a home health agency. Limited to 100 visits per year (within overall limit of 100 visits from a home health agency per year). No requirements for prior authorization. Reimbursement on basis of reasonable cost (payment basis used by Social Security Administration for Medicare). Claims processed and paid by State Department of Public Welfare.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations. No requirements for prior authorization. Reimbursement of items furnished by a home health agency on basis of reasonable costs (payment basis used by Social Security Administration for Medicare); of items furnished by pharmacists under contract with State Department of Public Welfare, on basis of over-the-counter charge. Claims processed by fiscal agent (Travelers Insurance Company) and paid by State Department of Public Welfare.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. Limited to outpatient psychiatric clinics and community mental health centers that are under the supervision of the South Carolina Mental Health Commission. No requirements for prior authorization. Reimbursement on basis of a negotiated rate. Claims processed and paid by State Department of Public Welfare.</p>
<b>11. Dental Services</b>	<p>Provided. Limited to emergency dental care, i.e., services necessary to control bleeding, relieve pain, eliminate acute infection; operative procedures required to prevent pulpal death and imminent loss of teeth; and palliative therapy for pericoronitis associated with impacted teeth. Program excludes routine restorative procedures, dental adjustments, and root canal therapy. No requirements for prior authorization. Reimbursement on basis of usual and customary fees. Claims processed by fiscal agent (Travelers Insurance Company) and paid by State Department of Public Welfare.</p>
<b>12. Physical Therapy and Related Services</b>	<p><b>a. Physical Therapy</b>      Provided. Limited to persons age 65 or older covered by the State's buy-in agreement, and to services covered as benefits under title XVIII - Part B. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost as determined by Social Security Administration for Medicare. Claims processed by fiscal agent (Blue Cross and Blue Shield of South Carolina) and paid by State Department of Public Welfare.</p> <p><b>b. Occupational Therapy</b>      Provided. Limited to such therapy provided by a home health agency to persons age 65 or older covered by the State's buy-in agreement. Limited to 100 visits per year (within overall limit of 100 home health agency visits per year). Reimbursement on basis of reasonable cost (payment basis used by Social Security Administration). Claims processed by fiscal agent (Blue Cross and Blue Shield of South Carolina) and paid by State Department of Public Welfare.</p> <p><b>c. Speech Therapy</b>      Provided. Limited to such therapy provided by a home health agency to persons age 65 or older covered by the State's buy-in agreement. Limited to 100 visits per year (within overall limit of 100 home health agency visits per year). Reimbursement on basis of reasonable cost (payment basis used by Social Security Administration). Claims processed by fiscal agent (Blue Cross and Blue Shield of South Carolina) and paid by State Department of Public Welfare.</p> <p><b>d. Audiology</b>      Not provided.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs prescribed by physician or dentist. Limited to drugs and medicines essential to saving or (for persons receiving maintenance drugs) prolongation of life, and to those drugs that will tend to limit the need for hospitalization. Prior authorization of State agency Medical Director required for drugs not listed in State agency's approved drug Formulary. Reimbursement for legend drugs on basis of cost plus dispensing fee (\$1.90 for drug vendors, \$1.00 for dispensing physicians, hospital and nursing home pharmacies); for non-legend drugs on basis of cost plus 50%. Claims processed and paid by State Department of Public Welfare.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Not provided.  [Exception: Provided as prescribed by ophthalmologists for post-operative need.]
<b>b. Hearing Aids</b>	Not provided.
<b>c. Dentures</b>	Not provided.
<b>d. Other Prosthetic Devices</b>	Provided. Braces, artificial limbs and eyes. No limitations. Prior authorization required for all items. Reimbursement on basis of reasonable charges (payment basis used by Social Security Administration for Medicare). Claims processed and paid by State Department of Public Welfare.
<b>15. Family Planning Services</b>	Not provided.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. For emergency care necessary to prevent loss of life or physical impairment and until patient can safely be transferred to a participating hospital. Reimbursement on basis of reasonable cost. Claims for services provided to persons age 65 or older processed by fiscal agent (Blue Cross and Blue Shield of South Carolina); for persons under age 65, by State Department of Public Welfare. Claims paid by State Department of Public Welfare.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. No limitations for ambulance services up to a 50 mile radius. Prior authorization required from State Office if beyond 50 mile radius. Limitations apply only to persons less than 65 years of age. Reimbursement on basis of reasonable cost. Claims for persons age 65 or older processed by fiscal agent (Blue Cross and Blue Shield of South Carolina); for persons under age 65 by fiscal agent (Travelers Insurance Co.). Claims paid by State Department of Public Welfare.
<b>b. Other</b>	Not provided.





**C. Eligibility for Medical Assistance (Continued)**

	<i>Optional</i>
<b>b. FFP Claimed in Administrative Costs Only</b>	<p>(1) General Assistance recipients.</p> <p>(2) Essential persons in the assistance households who are not categorically related.</p> <p>(3) Any such persons who would be recipients except for any eligibility or other condition specifically prohibited by Title XIX.</p>
<b>4. Coverage of the Medically Needy</b>	Not included.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	Not applicable.
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.
<b>7. Identification to Vendors of Persons Eligible</b>	An Identification Card is provided along with the monthly check together with an explanation of its purpose.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Division of Medical Assistance is one of the major divisions responsible to the Director of the Department of Public Welfare. The Chief is from the field of Social Work Administration, a Medical Doctor serves half-time, and two pharmacy consultants part-time.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the general field staff of the agency, which consists of six full-time supervisors and six full-time consultants providing consultative services.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as The Advisory Committee to Title XIX. It is composed of 18 members appointed by the Governor. There is one ex officio member, the Governor. Authority for the Committee is administrative.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	For all services except those noted in Item b., below, the State Department of Public Welfare processes and pays all claims.
<b>b. Fiscal Agents</b>	<p>The State Department has contracts with two fiscal agents to <i>process</i> certain claims:</p> <p>(1) Travelers Insurance Company—for persons under age 65; claims for physicians, dentists, optometrists, ambulance, and "other laboratory and X-ray services".</p> <p>(2) Blue Cross-Blue Shield of South Carolina—for persons age 65 or older; claims for physicians, podiatrists, optometrists, ambulance, outpatient hospital services, "other laboratory and X-ray", and payment of coinsurance and deductibles under title XVIII.</p> <p>The State Department of Public Welfare makes payment of the claims.</p>



**D. Administration and Management (Continued)**

<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for South Carolina as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 78.68.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from annual appropriations from the General Fund and certain earmarked funds.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If funds are not sufficient to meet the State share of the cost of payments under the program, adjustments must be made so as to stay within the appropriation.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

SOUTH DAKOTA

**A. General Information**

<b>1. Legal Base</b>	Chapter 191 of the Session Laws of 1966.
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1967. Original plan approved by the Federal agency on August 31, 1967.
<b>3. Administrative Responsibility</b>	The State Department of Public Welfare serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices, some of which serve more than one county.
<b>4. Historical Background</b>	<p>Provisions for vendor payment of costs of medical care with Federal financial participation began in August 1961 for OAA recipients only, based on 1957 legislation and a 1961 special appropriation. The services were physicians' services and inpatient hospital care. By late 1962, payments for services of chiropractors and optometrists had been added. On July 1, 1965, nursing home care for recipients of OAA, AB, and APTD was added to the program under vendor payment provisions; and in April 1966, vendor payment for dentures and denture repair was added for OAA only; for the other categories such service was in the money payment.</p> <p>In the meantime, legislation in 1963 and 1964 authorized a Federal-State program of Medical Assistance for the Aged for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. The State agency contracted with Associated Hospital Services, Inc., (Blue Cross) and South Dakota Medical Services, Inc., (Blue Shield) for hospital and physicians' services on an insurance basis with monthly premium payments for MAA patients. Nursing home care was added to the scope of services in 1965 at the same time it was added to the services for money payment recipients. The insurance contract was terminated July 1, 1966, to phase out the program and to accommodate to the services available through title XVIII Medicare. The MAA program remained in effect until the implementation of title XIX.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exception:</p> <p>Certain services provided to all recipients are made available on a more liberal basis to persons covered by the State's buy-in agreement. (Items B.7.a.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. Up to 30 days per benefit period (as defined in title XVIII). No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Associated Hospital Services, Inc.).
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable costs computed on same basis as under title XVIII. Claims processed and paid by fiscal agent (Associated Hospital Services, Inc.).



**B. Medical and Remedial Care and Services (Continued)**

<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No limitations. No requirements for prior authorization. Reimbursement on basis of certified costs on per diem basis within established limits according to the needs of the individual and the services provided by the facility. Claims processed and paid by State Department of Public Welfare.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. One visit per month for chronic condition; 4 visits per month for acute condition. No requirements for prior authorization. Reimbursement on basis of reasonable and customary charges not to exceed \$4.50 per unit value in accordance with fee schedule negotiated with South Dakota Association of Podiatrists. Claims processed and paid by State Department of Public Welfare.
<b>b. Optometrists</b>	Provided. No limitations. [See Item B.14.a. eyeglasses.] Prior approval of State Department required. Reimbursement on basis of reasonable and customary charges not to exceed \$3.75 per unit in accordance with fee schedule negotiated with the South Dakota Vision Service Corporation. Claims processed and paid by State Department of Public Welfare.
<b>c. Chiropractors</b>	Provided. Up to 24 visits per year. No requirements for prior authorization. Reimbursement on basis of reasonable costs in accordance with Relative Value Study negotiated with South Dakota Chiropractors' Association. Claims processed and paid by State Department of Public Welfare.
<b>d. Other</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided if furnished by an approved home health agency, or by others under arrangements made by such agency. Up to 100 visits per calendar year (within overall limit of 100 visits from a home health agency per year). No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (Associated Hospital Services, Inc.).</p> <p>(b) Services of home health aide. Provided if furnished by a home health agency. Up to 100 visits per calendar year (within overall limit of 100 visits from a home health agency per year). No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).</p>
<b>11. Dental Services</b>	<p>Not provided except for dentures; see Item 14.c., below.</p> <p>[Also services of a doctor of dentistry or of dental or oral surgery are provided with respect to (a) surgery related to the jaw or any structure contiguous to the jaw or (b) the reduction of any fracture of the jaw or any facial bone.]</p>
<b>12. Physical Therapy and Related Services</b>	<p><b>a. Physical Therapy</b></p> <p>Provided. No limitations if physician recommends and service is received through a Home Health agency. No requirements for prior authorization. Reimbursement on basis of usual and customary charges within established limitations. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).</p> <p><b>b. Occupational Therapy</b></p> <p>Provided. No limitations if physician recommends and service is received through a Home Health agency. No requirements for prior authorization. Reimbursement on basis of usual and customary charges within established limitations. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).</p> <p><b>c. Speech Therapy</b></p> <p>Provided. No limitations if physician recommends and service is received through a Home Health agency. No requirements for prior authorization. Reimbursement on basis of usual and customary charges within established limitations. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).</p> <p><b>d. Audiology</b></p> <p>Not provided.</p>
<b>13. Prescribed Drugs</b>	<p>Not provided.</p>
<b>14. Prosthetic Devices</b>	<p><b>a. Eyeglasses</b></p> <p>Provided. Subject to a \$7 maximum for cost of frames. Prior authorization required from State agency. Reimbursement on basis of usual and customary charges within the specified maximums. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).</p> <p><b>b. Hearing Aids</b></p> <p>Not provided.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>c. Dentures</b>	Provided. Initial dentures and repair or replacement of dentures. Prior authorization required from State Department. Reimbursement on basis of usual and customary charges within established limitations of dental fee schedule negotiated with the South Dakota Dental Association. Claims processed and paid by State Department of Public Welfare.
<b>d. Other Prosthetic Devices</b>	Provided. Including replacement of such devices as leg, arm, back, and neck braces; and artificial legs, arms, and eyes, including replacements if required because of a change in the patients physical condition. No limitations. No requirement for prior authorization. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (South Dakota Medical Service, Inc.).
<b>15. Family Planning Services</b>	Provided. Drugs, supplies, and devices when such services are under the supervision of a physician. Reimbursement on basis of usual and customary charges for such items prescribed. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. No limitations. No requirements for prior authorization. There are 4 hospitals that are licensed but not qualified under Medicare. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Associated Hospital Services, Inc.).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. For emergency only. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (South Dakota Medical Services, Inc.).
<b>b. Other</b>	Not provided.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month prior to the month of application provided all conditions of eligibility were met in the month in which services were rendered.
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### C. Eligibility for Medical Assistance (Continued)

<b>2. Conditions of Eligibility</b> <b>(By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.  (2) Child in AFDC foster care.  (3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  (4) Person who is blind (State definition) and age 18 or older.  (5) Person who is permanently and totally disabled (State definition) and age 18 or older.
<b>b. Age 21 to 64</b>	(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.  (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)  (2) Person who is blind (State definition).  (3) Person who is permanently and totally disabled (State definition).
<b>c. Age 65 or older</b>	(1) Individual who has attained age 65.
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
<b>a. FFP Claimed in Medical and Administrative Costs</b>	<p style="text-align: center;"><i>Mandatory</i></p> (1) Recipients of OAA, AB, APTD, and AFDC.  (2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.  (3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.  <p style="text-align: center;"><i>Optional</i></p> (4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.  (5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.
<b>b. FFP Claimed in Administrative Costs Only</b>	<p style="text-align: center;"><i>Optional</i></p> None.
<b>4. Coverage of the Medically Needy</b>	Not included.



**C. Eligibility for Medical Assistance (Continued)**

<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	Not applicable.
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21.
<b>7. Identification to Vendors of Persons Eligible</b>	Identification card is issued monthly with the check to the recipient of a money payment. Card lists eligible family members. Card bears a notice to the vendor to notify the local welfare office within 72 hours of the admission of a recipient to inpatient care or the giving of outpatient care.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	Responsibility for direction of the program is placed in the Medical Administration. The Director (M.D.) is responsible directly to the head of the State Department of Public Welfare. Other full-time professional staff are an Assistant Director of Medical Administration (BS with graduate work in Education) and a Medical Consultant (MSW). [No services of dentist or pharmacist consultants because these medical services are not within the scope of the program.]
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through Regional Directors, full-time, who are assigned to specific areas of the State and are involved with all program operations. The 43 local agency supervisors serve all 67 counties of the State.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Advisory Committee. It is composed of nine members appointed by the State Director of Public Welfare. There are no ex officio members. Authority for the Committee is administrative.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act. Liability of the title XIX program for recipients with title XVIII-B coverage extends only to the deductible and coinsurance amounts for services to which the individual is eligible under Title XVIII-B.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Public Welfare processes and pays all vendor claims for services provided to recipients except those processed and paid by the two fiscal agents. (See b. below.)
<b>b. Fiscal Agents</b>	The State Department of Public Welfare has entered into two fiscal agent contracts for the processing and payment of claims for certain kinds of services: (1) for in-State physicians' services, the South Dakota Medical Services, Inc., (Blue Shield); (2) for in-State inpatient hospital services, out-patient hospital services, and home health services, the Associated Hospital Services, Inc., (Blue Cross).
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for South Dakota as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 69.91 percent.
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**E. Financing (Continued)**

<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually from the State's general funds in a specific amount. Unobligated balance may not be carried over but reverts to the General Fund at the end of each fiscal year.
<b>4. Deficit financing</b>	There is no authority for deficit financing. In an extreme emergency the Governor can authorize drawing on the next year's appropriation.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Health

January 1, 1970

TENNESSEE

**A. General Information**

1. Legal Base	Public Chapter No. 551, Laws 1968, the "Medical Assistance Act of 1968." (Tennessee Code Annotated, Chapter 19, sections 901 through 922), as amended.
2. Beginning Dates	Program went into operation on October 1, 1969. Original plan approved by the Federal agency on October 10, 1969.
3. Administrative Responsibility	<p>The Tennessee Department of Public Health serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices.</p> <p>The Tennessee Department of Public Welfare is responsible for determination of eligibility for medical assistance.</p>
4. Historical Background	<p>Beginning in 1957, vendor payments were made by the State Department of Public Welfare for costs of hospitalization for acutely ill recipients in OAA, AB, APTD, and AFDC. The terms of the State statute were broad, but limitations of funds restricted the scope of services. Nursing home care for OAA was added in January 1961; but this service for AB and APTD recipients was provided through the money payment to recipients throughout the period prior to the Medicaid (title XIX) program. In July 1963, the nature of need for hospitalization was broadened and at the same time provisions for payment of costs of certain prescribed drugs were implemented.</p> <p>The 1961 session of the legislature authorized a Federal-State program of Medical Assistance for the Aged (persons age 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need). The services provided were limited hospitalization for acute illness or injury and prescribed drugs limited to "essential life-saving drugs for treatment of diabetes and cardiac conditions"; and in October 1962, payment for nursing home care was added. Subsequently, the definitions of need for hospitalization and the list of drugs were liberalized. At the time of the enactment of title XVIII of the Social Security Act (Medicare), the services provided through the public assistance titles and through MAA were modified to correlate them with services available to aged recipients eligible for and enrolled in the Medicare program.</p>
5. Scope of Coverage	Program provides coverage for categorically needy persons only. (See Item C.3.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.; B.4.b. and c.)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Items B.7.a.; B.8.(b) and (c); B.10.; B.12.a., b., and c.; B.14.d.; B.21.a.)</p> <p>Certain services covered as benefits under Medicare are made available on a more limited basis to individuals covered by the State's buy-in agreement than to others. (Items B.2.; B.3.; B.8.(a).)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to 20 days per fiscal year. No requirements for prior authorization, but medical certification as to need and written orders for care are mandatory. Reimbursement on basis of reasonable cost (as determined by title XVIII principles and methods). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).</p> <p>Provided. Limited to persons age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (as determined by title XVIII principles and methods). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).</p> <p>Provided. Limited to persons age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (as determined by title XVIII principles and methods). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. Unlimited services for persons age 65 or older covered by State's buy-in agreement; for others, limited to 30 visits per fiscal year. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. Unlimited services for persons age 65 or older covered by State's buy-in agreement; for others, limited to 30 occasions per year (a visit constitutes "an occasion"). No requirements for prior authorization. Reimbursement on basis of reasonable charges. Claims processed and paid by fiscal agent (Equitable Life Assurance Society).</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to persons age 21 or older, and to 90 days per fiscal year. May be extended in 30-day increments upon physician's justification and point system evaluation. No requirements for prior authorization, but medical certification by attending physician is required on admission, with recertification on or before the 14th day, and subsequent recertification at intervals of 30 days or less. Reimbursement limited to maximum \$12 per diem payment. Supplementation by relatives or other third parties permitted. Maximum allowable reimbursement limited to reasonable cost (determined on basis of title XVIII principles and methods). If, during a cost settlement report period, amount collected by nursing home for <i>all</i> recipients (combination of \$12 maximum State payments, budgeted income of recipients, and supplemental payments) exceeds actual and audited costs, excess must be refunded to State agency. Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).</p> <p>Provided. Limited to persons age 65 or older in public or private institutions. No other limitations. No requirement for prior authorization, but physician's justification and point system evaluation required. Reimbursement on basis of reasonable cost (as determined by title XVIII principles and methods). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).</p> <p>Provided. Limited to persons age 65 or older in public or private institutions. No other limitations. No requirement for prior authorization, but physician's justification and point system evaluation required. Reimbursement on basis of reasonable cost (as determined by title XVIII principles and methods). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. Special recommendation and specific authorization by State office required for cosmetic surgery. Reimbursement on basis of usual and customary fees, not to exceed 75th percentile. Reimbursement for services to hospital inpatient limited to 50% of usual and customary fee. Claims processed and paid by fiscal agent (Equitable Life Assurance Society).
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement, and to such services available as benefits under Medicare. Reimbursement on basis of buy-in agreement (according to the way Medicare pays). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).
<b>b. Optometrists</b>	Not provided.
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermediate or part-time nursing service. Provided. As furnished by a certified home health agency. For persons age 65 or older covered by State's buy-in agreement, limited to 100 visits per year (in combination with all other visits from a home health agency). For all others, limited to 60 visits per year. No requirements for prior authorization. Reimbursement on basis of reasonable cost (title XVIII principles and methods). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).</p> <p>(b) Services of home health aide. Provided. As furnished by a certified home health agency. Limited to persons age 65 or older covered by State's buy-in agreement, and to 100 visits per year (in combination with all other visits from a home health agency). No requirements for prior authorization. Reimbursement on basis of reasonable cost (title XVIII principles and methods). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. Limited to persons age 65 or older covered by State's buy-in agreement; consisting of rental or purchase of durable equipment and other items available as benefits under Medicare, Part B. No requirements for prior authorization. Reimbursement on basis of title XVIII principles and methods. Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement. No other limitations. No requirements for prior authorization. Reimbursement on basis of buy-in agreement (title XVIII Medicare). Claims processed and paid by fiscal agent (Equitable Life Assurance Society).
<b>11. Dental Services</b>	Not provided. [Except for emergency oral surgery.]
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement and to such services as are available as benefits under Medicare, Part B. No requirements for prior authorization. Reimbursement on basis of buy-in agreement (according to title XVIII - Medicare). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Occupational Therapy</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement, and to such therapy when furnished by a certified home health agency. 100 visits per year (in combination with all other visits from home health agency). No requirements for prior authorization. Reimbursement on basis of cost as determined by Title XVIII method. Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).
<b>c. Speech Therapy</b>	Provided. Limited to persons age 65 or older covered by State's buy-in agreement, and to such therapy when furnished by a certified home health agency. 100 visits per year (in combination with all other visits from home health agency). No requirements for prior authorization. Reimbursement on basis of cost as determined by Title XVIII method. Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).
<b>d. Audiology</b>	Not provided.
<b>13. Prescribed Drugs</b>	Provided. Legend drugs and insulin. Maximum of 2 refills per prescription, obtained within 90 days of original prescription. Original prescription not to exceed 30 day supply; quantity of refill not to exceed amount of original prescription. No requirements for prior authorization. Reimbursement on basis of documented acquisition cost (substantiated by invoice) plus professional fee of \$1.50 per prescription. Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided but only following cataract surgery.
<b>b. Hearing Aids</b>	Not provided.
<b>c. Dentures</b>	Not provided.
<b>d. Other Prosthetic Devices</b>	Provided. To persons age 65 or older covered by State's buy-in agreement. Limited to prosthetic devices, braces, artificial limbs and eyes, and other items available as benefits under Medicare, Part B. Prior authorization required when furnished as part of authorized treatment for persons under 65 years of age. Reimbursement on basis of cost as determined by title XVIII - Medicare method.  Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).
<b>15. Family Planning Services</b>	Provided. Legend drugs only. [Other services available through clinics of Department of Public Health.]
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. Limited to 10 days per fiscal year. No requirements for prior authorization. Reimbursement on basis of reasonable cost (as determined by title XVIII principles and methods). State payment not to exceed \$10 per day. Claims processed and paid by fiscal agent (Equitable Life Assurance Society).
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. When necessary to prevent death, serious impairment of health, or unnecessary suffering; and until patient can be moved to an approved hospital without undue danger to health or life. No requirements for prior authorization, but State agency must concur that such an emergency exists. Reimbursement on basis of reasonable cost (as determined by title XVIII principles and methods). Claims processed and paid by fiscal agent (Blue Cross-Blue Shield of Tennessee).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
a. Ambulance	Provided. Limited to persons age 65 or older covered by State's buy-in agreement, and to such services when available as benefits under Medicare, Part B. No requirements for prior authorization. Reimbursement on basis of Medicare guidelines. Claims processed and paid by fiscal agent (Equitable Life Assurance Society).
b. Other	Not provided.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is entitled to assistance beginning as early as the date of application, provided all conditions of eligibility were met on the date services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
a. Under Age 21	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p>
b. Age 21 to 64	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
c. Age 65 or older	(1) Individual who has attained age 65.
<b>3. Coverage of the Categorically Needy</b>	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
a. FFP Claimed in Medical and Administrative Costs	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p>

**C. Eligibility for Medical Assistance (Continued)**

b. FFP Claimed in Administrative Costs Only	<i>Optional</i>  None.
4. Coverage of the Medically Needy	Not included.
5. Financial Criteria	The following criteria are used in establishing financial eligibility for medical assistance:
a. For Categorically Needy Persons	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
b. For Medically Needy Persons	Not applicable.
6. Financial Responsibility of Relatives	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21.
7. Identification to Vendors of Persons Eligible	An "Eligibility Card" is issued each month by the State welfare office to each individual or head of an AFDC household certified as eligible for medical assistance. Face of card shows case identification number and period for which card is valid (first day of month of issuance to 10th day of month following). Date on card issued with initial payment begins with date of eligibility and extends through current period. Left hand side of card shows name, year of birth, and sex of each member of the case who is eligible for medical assistance, together with a coded indication as to whether he has available outside medical resources such as insurance.

**D. Administration and Management**

1. Medical Assistance Unit	The Medical Assistance Section (medical assistance unit) is located in the Division of Medical Care Services, an organizational segment of the Bureau of Personal Health Services of the Department of Public Health. In addition to the Director (LLB), full-time professional staff of the unit consists of a Medicaid Administrator (BS), a Medical Social Consultant (MSW), two Systems Analysts (BS), a Pharmacist Consultant, a Medicaid Administrative Specialist (BS), and 3 Regional Medicaid Administrators (BA). In addition, the services of a Medical Consultant (MD) are available on a part-time basis (3 days a week).
2. Supervision of Statewide Operations	Supervision of Statewide operations of the medical aspects is handled directly by staff of the State office. Supervision of eligibility determination is by the regular field staff of the Department of Public Welfare.
3. Advisory Council	The State advisory body for title XIX is known as the Medicaid Medical Advisory Committee. It is composed of 14 members appointed by the Governor. There are 4 ex officio members with voting privileges (Commissioners of Public Health, Public Welfare, Mental Health, and Education) and one ex officio member without voting privileges (Director, Medical Assistance Unit). Authority for the Committee is administrative.
4. Buy-In Agreement	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
5. Claims Payment Process	State agency is not directly engaged in the day-to-day processing and payment of medical vendor claims.



**D. Administration and Management (Continued)**

<b>b. Fiscal Agents</b>	State agency has entered into two fiscal agent contracts. Under one contract Blue Cross-Blue Shield of Tennessee receives, processes, reviews, pays, and audits claims received from hospitals (including hospitals for tuberculosis and mental diseases), home health agencies, pharmacists, and such vendors as are utilized in the provision of the special service designated as "Early screening, diagnosis, and treatment of children under 21". Under the other contract, the Equitable Life Assurance Society performs the same services with respect to claims received from physicians, independent laboratories, and Christian Science Sanatoria.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Tennessee as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 74.62.
<b>2. State/Local Participation</b>	State funds are used to pay 90% of the non-Federal share of program costs of both medical assistance and administration; the remaining 10% is derived from counties, which are billed for a pro rata share. If a county's share is not paid, State funds earmarked for the county are withheld.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually. Unobligated balance may not be carried over but reverts to the General Fund at the end of the fiscal year.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, a supplemental appropriation must be requested; if not granted, levels of vendor payments will be lowered.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Welfare

January 1, 1970

TEXAS

**A. General Information**

<b>1. Legal Base</b>	State of Texas Senate Bill No. 2, 60th Legislature, Regular Session, 1967, "The Medical Assistance Act of 1967", Article 695J; Vernon's Texas Civil Statutes.
<b>2. Beginning Dates</b>	Program went into operation on September 1, 1967. Original plan approved by the Federal agency on September 1, 1967.
<b>3. Administrative Responsibility</b>	The State Department of Public Welfare is the single State agency with responsibility for administering the program on a Statewide basis through a system of 16 regional offices which include unit supervisory offices serving all counties.
<b>4. Historical Background</b>	<p>The State Constitution was amended in 1958 to permit payments in behalf of recipients for medical care, and the 1961 session of the State Legislature authorized such payments for "hospitalization and surgical-medical benefits" and nursing home care for recipients of OAA. The appropriation became effective January 1, 1962. Services began in that month under a contract with Group Hospital Service, Inc., (Blue Cross) for the hospital-related services for OAA recipients. Thus Texas became the first State to develop a pre-payment insurance contract for medical care of aged recipients of public assistance. Nursing home care was not covered in the insurance contract but was paid for by the Department of Public Welfare directly to the providers of such care. Other medical needs of OAA recipients and the needs of recipients of AB, APTD, and AFDC were recognized in the State's standard of assistance, but provisions to include the cost of needed care in the individual's money payment for subsistence needs were limited by the maximum permissible for the total money payment per month.</p> <p>In July 1966, enabling legislation extended vendor payments to recipients of AB, APTD, and AFDC. The program continued in effect until the implementation of title XIX in 1967.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c)</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p> <p>Certain services are made available only to persons age 65 or older. (Items B.8; B.12.a., b., and c; B.14.d)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	<p>Provided. Including private accommodations if required for medical reasons. Limited to 30 days in a spell of illness (new spell of illness begins when individual has not been an inpatient in a hospital for 60 consecutive days). No requirements for prior authorization. Payment made only to hospitals approved by and having a signed agreement with the State agency. Reimbursement on basis of reasonable cost (determined on same basis used by Medicare). Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).</p> <p>Services also provided in approved hospital units of State Institutions for Mentally Retarded for patients who are categorically needy. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.</p>



**B. Medical and Remedial Care and Services (Continued)**

b. In Institutions for Tuberculosis	Provided. Limited to patients age 65 or older in State institutions for tuberculosis. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.
c. In Institutions for Mental Diseases	Provided. Limited to patients age 65 or older in State institutions for mental diseases. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.
2. Outpatient Hospital Services	Provided. Excluding routine physical examinations. Outpatient psychiatric care limited to the lesser of \$312.50 or 62½% of the expense per recipient per calendar year. No requirements for prior authorization. Except for emergencies, payment made only to hospitals approved by and having a signed agreement with the State agency. Reimbursement on basis of reasonable cost. Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).
3. Other Laboratory and X-ray Services	Provided. Excluding routine physical examinations. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charge. Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).
4. Skilled Nursing Home Services  a. General	Provided. Limited to persons age 21 or older. No other limitations. Medical Assistance Unit of Department of Public Welfare must type patient as needing skilled level of nursing care. No requirements for prior authorization. Home must be certified by State Health Department as skilled nursing home and have a signed contract with the Department of Public Welfare. Reimbursement on basis of negotiated fixed rate by classification of home and type of care provided. Services also provided in units of State Institutions for the Mentally Retarded which have been approved as skilled nursing home care units, for categorically needy patients declared by Medical Assistance Unit as needing skilled level of nursing care. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Welfare.
b. In Institutions for Tuberculosis	Not provided.  [Care in State institutions for tuberculosis considered as inpatient hospital care.]
c. In Institutions for Mental Diseases	Not provided.  [Care in State institutions for mental diseases considered as inpatient hospital care.]
5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21	Not provided.
6. Physicians' Services (M.D. and D.O.)	Provided. Excluding routine physical examinations. Outpatient psychiatric services limited to the lesser of \$312.50 or 62½% of the expense per recipient per calendar year. No requirements for prior authorization. Reimbursement on basis of usual, customary, and prevailing charges. Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).
7. Services of Licensed Practitioners  a. Podiatrists	Provided. Limited to \$15 per recipient per State fiscal year, for podiatric examinations; no payment for radiological services, laboratory examinations, or therapeutic services. No requirements for prior authorization. Reimbursement on basis of usual, customary, and prevailing charges. Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).  [Up to \$6 per month for therapeutic treatment by podiatrist may be included as special needs item in assistance budget of OAA, AB, APTD or AFDC recipient; total grant not to exceed maximum on money payment for each category.]

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Optometrists</b>	Provided. Limited to one eye refraction ("performed by a licensed ophthalmologist or optometrist") per State fiscal year per recipient. Payment made for post-surgical lenses following cataract surgery and required during convalescence. No payment for subsequent cataract lenses or other eye glasses. No requirements for prior authorization. Reimbursement on basis of usual, customary, and prevailing charges. Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).
<b>c. Chiropractors</b>	<p>Provided. Examination only, not to exceed \$15 per State fiscal year per recipient; excluding treatment, laboratory examinations, X-ray, and any other services provided by chiropractor. No requirements for prior authorization. Reimbursement on basis of usual, customary and prevailing charge. Claims processed and paid by State Department of Public Welfare.</p> <p>[Up to \$6 per month for treatment of chronic illness by chiropractor may be included as special needs item in assistance budget of OAA, AB, APTD, or AFDC recipient; total grant not to exceed maximum on money payment for each category.]</p>
<b>d. Other</b>	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home (not including hospital, skilled nursing home, or Intermediate Care III facility) when provided by a Home Health Agency approved by and having a signed agreement with the Department of Public Welfare, subject to the same conditions and limitations appertaining under Part B. of Medicare:</p> <p>(a) Intermittent or part-time nursing services. Provided. Limited to persons age 65 or older. 100 home health agency visits per calendar year (combined total of all types of visits furnished by such agency). No requirements for prior authorization. Reimbursement on basis of reasonable cost (as computed for title XVIII). Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).</p> <p>(b) Services of Home Health Aide. Provided. Limited to persons age 65 or older. 100 home health agency visits per calendar year (combined total of all types of visits furnished by such agency). No requirements for prior authorization. Reimbursement on basis of reasonable cost (as computed for title XVIII). Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. Limited to persons age 65 or older. Rental of durable medical equipment included when provided by Medicare-approved supplier. Reimbursement on basis of reasonable charges (as computed for title XVIII). Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	Not provided.
<b>11. Dental Services</b>	<p>Not provided.</p> <p>[While general dentistry is not provided, vendor payment is made for oral surgery related to the jaw or contiguous structure and for reduction of any fracture of the jaw or any facial bone. In addition, up to \$6 per month for treatment of a chronic illness by a dentist may be included as a special needs item in the assistance budget of an OAA, AB, APTD, or AFDC recipient; total grant not to exceed maximum on money payment for each category.]</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>12. Physical Therapy and Related Services</b>	
a. Physical Therapy	Provided. Limited to persons age 65 or older. Subject to same conditions and limitations appertaining under Part B—Medicare. No requirements for prior authorization. Reimbursement to approved home health agency on basis of reasonable cost. Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).
b. Occupational Therapy	Provided. Limited to persons age 65 or older. Subject to same conditions and limitations appertaining under Part B—Medicare. No requirements for prior authorization. Reimbursement to approved home health agency on basis of reasonable cost. Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).
c. Speech Therapy	Provided. Limited to persons age 65 or older. Subject to same conditions and limitations appertaining under Part B—Medicare. No requirements for prior authorization. Reimbursement to approved home health agency on basis of reasonable cost. Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).
d. Audiology	Not provided.
<b>13. Prescribed Drugs</b>	Not provided.  [An amount for prescribed medications for chronic illness may be included as a special needs item in assistance budget of an OAA, AB, APTD, or AFDC recipient on an actual cost basis; total grant not to exceed maximum on money payment for each category.]
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Not provided.  [Vendor payment is made by insurance carrier (Group Hospital Service, Inc.) to ophthalmologist or optometrist for post-surgical lenses following cataract surgery and required during convalescence (See Item B.7.b.); no vendor payment for subsequent cataract lenses or other eyeglasses. Up to \$15 for eyeglasses may be included as a special needs item in assistance budget of an OAA, AB, APTD, or AFDC recipient; total grant not to exceed maximum on money payment for each category.]
b. Hearing Aids	Not provided.  [Up to \$72 for hearing aid may be included as a special needs item in assistance budget of an OAA, AB, APTD, or AFDC recipient; total grant not to exceed maximum on money payment for each category.]
c. Dentures	Not provided.  [Up to \$60 for dentures may be included as a special needs item in the assistance budget of an OAA, AB, APTD, or AFDC recipient; total grant not to exceed maximum on money payment for each category.]
d. Other Prosthetic Devices	Provided. Prosthetic devices to replace all or part of an internal body organ; braces, artificial limbs, artificial eyes; and replacements as required by change in patient's condition. Limited to persons age 65 or older. Subject to same conditions and limitations appertaining under Part B—Medicare. No requirements for prior authorization. Reimbursement on basis of reasonable charges (as computed for title XVIII). Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).
<b>15. Family Planning Services</b>	Not provided.
<b>16. Services of Christian Science Nurses</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

17. Care and Services in Christian Science Sanatoria	Not provided.
18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)	Provided. As medically necessary, when emergency verified by physician. Approval of State agency required prior to payment. Reimbursement on basis of reasonable cost. Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).
19. Personal Care Services In Patient's Home	Not provided.
20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services	Not provided.
21. Transportation	
a. Ambulance	Provided. For all eligible persons, when medically necessary. Subject to same conditions and limitations appertaining under Medicare. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charge. Claims processed and paid by insurance carrier (Group Hospital Service, Inc.).
b. Other	Not provided.  [Transportation is included in the personal need allowance in the assistance budget of an OAA, AB, APTD, or AFDC recipient; total grant not to exceed maximum on money payment for each category.]

**C. Eligibility for Medical Assistance**

1. Date of Entitlement	<p>An applicant's eligibility for medical assistance begins on whichever of the following dates occurs first:</p> <ul style="list-style-type: none"> <li>a. Date of application (if subsequently found eligible on that date);</li> <li>b. Date on which eligibility is subsequently gained (if found not eligible as of date of application);</li> <li>c. First day of month in which a processible eligibility document is received in State office.</li> </ul>
2. Conditions of Eligibility (By Age Groups)	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p> <ul style="list-style-type: none"> <li>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</li> <li>(2) Child in foster home or private non-profit institution for whom the State Department of Public Welfare is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</li> <li>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</li> <li>(4) Person who is blind (State definition) and age 18 or older.</li> <li>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</li> </ul>
a. Under Age 21	



### C. Eligibility for Medical Assistance (Continued)

b. Age 21 to 64	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p>
c. Age 65 or older	(1) Individual who has attained age 65.
<p>3. Coverage of the Categorically Needy</p> <p>a. FFP Claimed in Medical and Administrative Costs</p> <p>b. FFP Claimed in Administrative Costs Only</p>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(5) Children under age 21 in foster homes or private non-profit institutions for whom the State Department of Public Welfare is assuming financial responsibility in whole or in part.</p> <p style="text-align: center;"><i>Optional</i></p> <p>None</p>
4. Coverage of the Medically Needy	Not included.
<p>5. Financial Criteria</p> <p>a. For Categorically Needy Persons</p> <p>b. For Medically Needy Persons</p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p>Not applicable.</p>
6. Financial Responsibility of Relatives	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21.
7. Identification to Vendors of Persons Eligible	Computer-generated "Medical Care Identification Card" is issued to eligible persons by State office each month. Card attests to eligibility for that month only. Card shows: effective month of eligibility; recipient's identification number, composed of program category, case number, and individual identification number; for recipients 65 years of age or over, Social Security Administration claim number; and name and number of each of the recipient's dependents who are eligible for medical care benefits (dependents listed are also certified recipients in their own rights). Cards are prepared and mailed to recipients each month.

## D. Administration and Management

<b>1. Medical Assistance Unit</b>	<p>The Assistant Commissioner for Medical Administration, a physician, is directly responsible to the Commissioner of the Department. Full-time professional staff assigned to the Medical Assistance Unit consists of the following: Director of Medical Assistance (M.D.); Director of Medical Services (M.D.); Assistant to the Assistant Commissioner — Title XIX (MSW); Administrative Assistant (MSW); Chief, Staff Physician, Nursing Homes (M.D.); Chief, Nursing Homes Public Assistance Affairs Section (MSW); Chief, Nursing Homes Patient Care Affairs Section (R.N.); Administrative Assistant (Medical Care Administration); Pharmaceutical Consultant (Pharmacist); Chief, Liaison Section, State Health Department Certification, Nursing Homes (Social Work); 2 Case Analysts, Vendor Typing Nursing Care (Social Work); Chief, Institutional Services Section (MSW); Chief, Disability Determination Section (Social Work); 2 Staff Physicians (M.D.); Disability Determination Analyst (Psychologist); 4 Disability Determination Analysts (MSW); 2 Disability Determination Analysts (Social Work); Director, Medical Assistance Unit 2 (M.D.); Medical Services Consultant (MSW); Medical Services Analyst (MSW); 3 Nurses (R.N.); Medical Assistance Administrator (Social Work); 11 Medical Facility Advisors (Social Work); and 3 Institutional Services Consultants (MSW). Part-time professional staff consists of a Psychiatric Consultant (Psychiatrist) and a State Reviewing Ophthalmologist.</p>						
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of Statewide operations is accomplished through the Departmental staff, Field Operations Division, consisting of one Director, one Assistant Director and three Directors of Field Staff (Social Work or MSW background) and 16 Regional Directors (Social Work or MSW background). Program direction and consultation are provided by Financial Services Division, Social Services Division, and Medical Administration.</p> <p>For the medical aspects of the program, consultative and other activities are provided by staff listed in D.1. above. Of the staff listed in D.1. above, the following are based in the Regions: Regional Medical Assistance Unit No. 2 serves three Regions and is composed of a Physician Director, Administrative Assistant, one Nurse (R.N.), one Institutional Consultant (MSW), one Medical Facility Advisor (Social Work). In other Regions of the State there are a total of two Nurses (R.N.) and eleven Medical Facility Advisors, and three Institutional Consultants. Staff of the Medical Assistance Unit headquartered in the State Office provides consultative and other services on an "at-large" basis when services are required by Regions not having an appropriate Medical Assistance Unit staff person headquartered in or serving that Region.</p>						
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Medical Care Advisory Committee. It is composed of 20 members appointed by the Commissioner of Public Welfare and 7 ex officio members: (3 Medical School representatives, 2 Health Insuring Organization representatives, 1 State Department of Health representative, and 1 representative from State Department of Mental Health and Mental Retardation). Authority for the Committee is statutory.</p>						
<b>4. Buy-In Agreement</b>	<p>State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all recipients eligible for Title XIX and eligible for enrollment under Part B, Medicare (Title XVIII) in accordance with the buy-in agreement.</p>						
<b>5. Claims Payment Process</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"><b>a. State and Local Agencies</b></td><td>The State Department of Public Welfare processes and pays claims of providers of inpatient hospital services in institutions for tuberculosis, institutions for mental diseases, and institutions for mentally retarded; skilled nursing home services (general and institutions for mentally retarded); and services of chiropractors. Claims from providers of all other medical care provided under the plan are handled through the insurance contract with Group Hospital Service, Incorporated. (See Item c. below.)</td></tr> <tr> <td><b>b. Fiscal Agents</b></td><td>None.</td></tr> <tr> <td><b>c. Prepaid Capitation Arrangements</b></td><td>State Department of Public Welfare has an insurance contract with Group Hospital Service, Inc., (Blue Cross-Blue Shield of Texas) whereby a monthly premium is paid for each recipient of public assistance. The following amounts were in effect January 1970: OAA and AB recipients over age 65, \$9.33; AB under age 65 and APTD recipients, \$59.98; AFDC, \$13.19. The contract covers all services under the title XIX plan except those for which the Department of Public Welfare pays directly (see Item a. above).</td></tr> </table>	<b>a. State and Local Agencies</b>	The State Department of Public Welfare processes and pays claims of providers of inpatient hospital services in institutions for tuberculosis, institutions for mental diseases, and institutions for mentally retarded; skilled nursing home services (general and institutions for mentally retarded); and services of chiropractors. Claims from providers of all other medical care provided under the plan are handled through the insurance contract with Group Hospital Service, Incorporated. (See Item c. below.)	<b>b. Fiscal Agents</b>	None.	<b>c. Prepaid Capitation Arrangements</b>	State Department of Public Welfare has an insurance contract with Group Hospital Service, Inc., (Blue Cross-Blue Shield of Texas) whereby a monthly premium is paid for each recipient of public assistance. The following amounts were in effect January 1970: OAA and AB recipients over age 65, \$9.33; AB under age 65 and APTD recipients, \$59.98; AFDC, \$13.19. The contract covers all services under the title XIX plan except those for which the Department of Public Welfare pays directly (see Item a. above).
<b>a. State and Local Agencies</b>	The State Department of Public Welfare processes and pays claims of providers of inpatient hospital services in institutions for tuberculosis, institutions for mental diseases, and institutions for mentally retarded; skilled nursing home services (general and institutions for mentally retarded); and services of chiropractors. Claims from providers of all other medical care provided under the plan are handled through the insurance contract with Group Hospital Service, Incorporated. (See Item c. below.)						
<b>b. Fiscal Agents</b>	None.						
<b>c. Prepaid Capitation Arrangements</b>	State Department of Public Welfare has an insurance contract with Group Hospital Service, Inc., (Blue Cross-Blue Shield of Texas) whereby a monthly premium is paid for each recipient of public assistance. The following amounts were in effect January 1970: OAA and AB recipients over age 65, \$9.33; AB under age 65 and APTD recipients, \$59.98; AFDC, \$13.19. The contract covers all services under the title XIX plan except those for which the Department of Public Welfare pays directly (see Item a. above).						



**D. Administration and Management (Continued)**

<b>d. Payments to Non-Medical Institutions</b>	None.
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**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Texas as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 66.66.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially for each year of the biennium as two separate items: medical assistance for the categorically needy, and medical assistance for the categorically needy in State hospitals and State schools. These funds are not transferable between these two appropriation items. Unencumbered balances at the end of the first year of the biennium may or may not be reappropriated by the State Legislature.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. However, should appropriations for one or more of the four assistance programs be in excess of the amount required to meet authorized payments in full, this excess may be transferred to medical assistance.

# MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Social Services

January 1, 1970

UTAH

## A. General Information

1. Legal Base	Public Assistance Act of 1961, Sections 55-15-1 to 55-15-39, Utah Code Annotated, 1953, as amended.
2. Beginning Dates	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on July 1, 1966.
3. Administrative Responsibility	The Utah State Department of Social Services is the single State agency with responsibility for administering the program through the activities of 29 county offices.
4. Historical Background	The use of the vendor payment method of paying for the cost of medical services with Federal financial participation began in July 1957 for all public assistance categories. A broad range of medical services for recipients in all Federally aided categories was provided on a Statewide basis. Although the program was comprehensive in nature, with few variations between groups of recipients, the availability of services was restricted to some extent by limitations imposed on the amount or duration of individual items. In July 1961, on the basis of newly enacted legislation, a Federal-State program of Medical Assistance for the Aged (MAA) was instituted providing medical care for persons age 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need. Services provided under the MAA program generally paralleled those provided to public assistance recipients.
5. Scope of Coverage	Program provides for coverage of both categorically needy and medically needy persons. (See Items C.3. and C.4., below.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Item B.1.b.)</p>

## B. Medical and Remedial Care and Services

1. Inpatient Hospital Services	
a. In General Hospitals	Provided. Hospitalization for psychiatric care limited to 12 days in an accredited psychiatric ward, and 5 days in a general hospital which does not have an accredited psychiatric ward. No other limitations. No requirements for prior authorization, but payment for care beyond 60 days must be approved by State Department Medical Director. Reimbursement on basis of reasonable cost. Claims processed and paid by State Division of Family Services.
b. In Institutions for Tuberculosis	Provided. Limited to persons age 65 or older in separate wing for tubercular patients in Thomas D. Dee Memorial Hospital, Ogden, Utah (under special contract with Department of Social Services). No other limitations. No requirements for prior authorization. Reimbursement on basis of per diem cost. Claims processed and paid by State Division of Family Services.
c. In Institutions for Mental Diseases	Provided. Limited to persons age 65 or older in Utah State Mental Hospital. No other limitations. No requirements for prior authorization. Reimbursement on basis of per diem cost. Claims processed and paid by State Division of Family Services.
2. Outpatient Hospital Services	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Division of Family Services.
3. Other Laboratory and X-ray Services	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of 90% of Utah State Medical Association Relative Value Studies (1963). Claims processed and paid by State Division of Family Services.



**B. Medical and Remedial Care and Services (Continued)**

<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>          <b>b. In Institutions for Tuberculosis</b>          <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For persons of all ages. No limitations. No requirements for prior authorization. Patients classified according to a point system as needing either "less skilled care" or "skilled care", and reimbursement made at monthly rate of either \$265 or \$324. Payment by relative or other third party is deducted from maximum rate (i.e., amount ordinarily charged private pay patients). Claims processed and paid by State Division of Family Services.</p> <p>Not provided. [See Item B.1.b., Inpatient Hospital Services.]</p> <p>Not provided. [See Item B.1.c., Inpatient Hospital Services.]</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Not provided.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. One visit per month for chronic illness; one office visit per illness for uncomplicated respiratory infections and influenza; no extensions. Unlimited number of visits for acute conditions. Prior authorization from State Department required for certain procedures which are considered non-essential. Reimbursement on basis of fixed fee schedule, except that most specialists are reimbursed for office and hospital visits at 95% of fees listed in Utah State Medical Association Relative Value Studies (1963). Claims processed and paid by State Division of Family Services.</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>          <b>b. Optometrists</b>          <b>c. Chiropractors</b>          <b>d. Other</b>	<p>Provided. Limited to serious foot conditions, upon referral by physician. No requirements for prior authorization. Reimbursement on basis of fixed fee schedule. Claims processed and paid by State Division of Family Services.</p> <p>Provided. Limited to eye examinations, eyeglasses, and visual training. No requirement for prior authorization. Reimbursement on basis of fixed fee schedule. Claims processed and paid by State Division of Family Services.</p> <p>Provided. All claims reviewed and adjusted by Medical Consultants. No requirements for prior authorization. Reimbursement on basis of \$4 per visit. Claims processed and paid by State Division of Family Services.</p> <p>Naturopaths. Provided. Limited to minor surgery and obstetrics. No requirements for prior authorization. Reimbursement on basis of Utah State Medical Association Relative Value Studies (1963). Claims processed and paid by State Division of Family Services.</p>
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipients while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided if furnished by a home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule (\$8.00 per visit).</p> <p>(b) Services of home health aide. Provided if furnished by a home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of fee schedule (\$4.50 for first visit and \$3.00 for subsequent visits).</p> <p>(c) Medical supplies, equipment, and appliances. Provided when prescribed by physician. No requirements for prior authorization. Reimbursement on basis of prevailing rates. Claims processed and paid by State Division of Family Services.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>9. Private Duty Nursing Services (RN or LPN)</b>	Provided. Limited to services provided by registered nurse (RN) to hospital inpatients. No requirements for prior authorization. Reimbursement on basis of prevailing charges. Claims processed and paid by State Division of Family Services.
<b>10. Clinic Services (Other than Hospital)</b>	Not provided.
<b>11. Dental Services</b>	Provided. Orthodontia not included. Prior authorization by State office not required for routine dental work; required by State office for other dental procedures, partial and full dentures in adult cases, crowns, and bridge work. Reimbursement on basis of fixed fee schedule. Claims processed and paid by State Division of Family Services.
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. No limitations, but services must be provided on referral by attending physician and either be given in a hospital or purchased from a home health agency. No requirements for prior authorization. Reimbursement on basis of \$8 per treatment for home health agency and \$4 per treatment for private practicing therapist. Claims processed and paid by State Division of Family Services.
<b>b. Occupational Therapy</b>	Not provided.
<b>c. Speech Therapy</b>	Provided. No limitations, but services provided must be recommended by physician. Prior authorization required from State Division of Family Services. Payments made to home health agencies and private practicing speech therapists. Reimbursement as billed, up to reasonable charges. Claims processed and paid by State Division of Family Services.
<b>d. Audiology</b>	Provided. No limitations, but services provided must be recommended by physician. Prior authorization required from State Division of Family Services. Payments made to home health agencies and private practicing audiologists. Reimbursement as billed, up to reasonable charges. Claims processed and paid by State Division of Family Services.
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs. No limitations. Prior authorization required from State Division of Family Services for payments exceeding \$10 per month for an individual. Reimbursement on basis of pricing formula (cost as determined by vendor's invoice plus 50% plus dispensing fee of 45¢); minimum payment of \$1, regardless of formula. Claims processed and paid by State Division of Family Services.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of payment schedule. Claims processed and paid by State Division of Family Services.
<b>b. Hearing Aids</b>	Provided. No limitations, but must be recommended by physician. Prior authorization required from State Division of Family Services. Reimbursement on basis of billed charges, not to exceed reasonable charges. Claims processed and paid by State Division of Family Services.
<b>c. Dentures</b>	Provided. No limitations. Prior authorization required from State Division of Family Services. Reimbursement on basis of payment schedule, with limit of \$110 for single dentures, \$220 for denture set, and \$10 for dental repairs. Claims processed and paid by State Division of Family Services.
<b>d. Other Prosthetic Devices</b>	Provided. Prosthetic devices and appliances, including special shoes, leg and foot braces, and artificial limbs. No limitations, but must be upon physician's recommendation. Prior authorization required from county office for items costing \$25 or less; from State Division of Family Services for items costing over \$25. Reimbursement as billed, up to reasonable charges. Claims processed and paid by State Division of Family Services.



**B. Medical and Remedial Care and Services (Continued)**

<b>15. Family Planning Services</b>	Provided. No limitations, but must be on physician's prescription. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Division of Family Services.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Division of Family Services.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. Intra-county transportation by private ambulance up to \$15 per month per person, with county office approval; inter-county, up to \$25 one-way, or \$50 round trip, with county office approval. Extensions beyond these amounts require approval of State Division of Family Services. No payments to public agencies for ambulance service. Reimbursement on basis of billed charges, up to maximum amounts described above. Claims processed and paid by State Division of Family Services.
<b>b. Other</b>	Provided. Travel by taxi, ambicab, bus, train, or other common carrier. Up to \$5 per month per person, with county office approval; inter-county, up to \$25 one-way or \$50 round trip, plus \$30 for subsistence, with county office approval; costs in excess of these amounts require prior approval of State Division of Family Services. Reimbursement for taxi or ambicab transportation on basis of flat rate negotiated with company; for other transportation, on basis of prevailing rate. Claims processed and paid by State Division of Family Services.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility, an individual is retroactively entitled to medical assistance under the program for services received within the 90 day period prior to the date of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	(1) Individual who has not attained age 21.

**C. Eligibility for Medical Assistance (Continued)**

<b>b. Age 21 to 64</b>	<p>(1) Parent or caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living, provided such child meets State's AFDC plan requirements as to age and school attendance. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p>
<b>c. Age 65 or older</b>	<p>(1) Individual who has attained age 65.</p>
<b>3. Coverage of the Categorically Needy</b>  <b>a. FFP Claimed in Medical and Administrative Costs</b>          <b>b. FFP Claimed in Administrative Costs Only</b>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Individuals under age 21.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only.)</p> <p>None.</p>
<b>4. Coverage of the Medically Needy</b>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a.(1) through (6), above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD, and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.</p>
<b>5. Financial Criteria</b>  <b>a. For Categorically Needy Persons</b>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>



**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p>(1) <i>Income</i></p> <p>Annual income which may be retained for basic maintenance needs: \$1260 for one person, \$1740 for 2 persons, \$2220 for 3 persons, \$2700 for 4 persons, \$3180 for 5 persons, plus \$360 for each additional person.</p> <p>Person in long-term care in a medical institution may retain \$5 per month for personal needs, and an additional \$105 for needs of spouse living at home.</p> <p>(2) <i>Resources</i></p> <p>Home may be retained regardless of value or equity, if owned and lived in.</p> <p>The following personal property is exempt, regardless of value: Clothing; furniture; one automobile; tools and equipment; livestock or food grown for family consumption.</p> <p>Income-producing real property may be retained up to a maximum net value of three times the annual maintenance base (see Item C.5.b.(1), above), but not to exceed \$7500.</p> <p>Non-income-producing property (real and personal) may be retained up to maximum net value of two times the annual maintenance base, but not to exceed \$5000.</p> <p>["Net value" is defined as gross market or cash value less any mortgages, liens, or other indebtedness for which the property is pledged as security.]</p> <p>Cash value of life insurance may be retained up to \$500 for one person or \$1000 for a family of 2 or more.</p> <p>Other liquid assets may be retained up to \$600 a year for one person, \$1200 for 2 persons, \$1300 for 3 persons, \$1325 for 4 persons, plus \$25 for each additional person.</p> <p>Excess of one kind of resource may not be substituted for or added to another type of resource, but must be applied to costs of medical care.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>An Identification Card is issued monthly to all persons eligible for medical assistance under the program, with the exception of medically needy persons with income in excess of the basic maintenance standard. For such persons, a statement of understanding is prepared citing the dollar amounts which the person has agreed to pay for medical goods or services received from specifically named vendors and stating that the Department will pay for services received in excess of those amounts. A copy of this statement is then furnished to each of the vendors named.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Medical Services Bureau (medical assistance unit) is located in the Social Service Branch of the Division of Family Services, State Department of Social Services. Full-time staff under the Chief (MSW) of the Bureau consists of a Medical Care Specialist (MSW), a Mental Health Specialist (MSW), and a Medical Assistance Representative (MSW). This staff is supplemented by the part-time services of 6 consultants (1 psychiatrist, 2 other M.D.'s, 1 dentist, 1 pharmacist, and 1 optometrist).</p>
<b>2. Supervision of Statewide Operations</b>	<p>Oversight of Statewide operation of the program is maintained in part through the activities of the staff of the Medical Services Bureau and in part through the supervisory activities of field staff of the Bureau of Program Operations of the Division of Family Services.</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Medical Advisory Committee. It is composed of 19 members appointed by the Director of the Division of Family Services. There are no ex officio members. Authority for the Committee is administrative.</p>

**D. Administration and Management (Continued)**

<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The Medical Claims Section of the Bureau of Finance, Division of Family Services, processes and pays all vendor claims for services provided to recipients under the program.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Utah as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 68.23.
<b>2. State/Local Participation</b>	State and local funds are used to meet the non-Federal share of costs of the medical assistance program under the following arrangement: County pays non-Federal share of expenditures for each recipient for inpatient hospital care beyond 20 days per admission, including physicians' services to hospital inpatients beyond that period, and for outpatient charges at the University Hospital in excess of \$2.50 per visit; State pays non-Federal share of all other medical expenditures. State funds are used to pay 100% of the non-Federal share of administrative expenses.
<b>3. Source of State Funds</b>	State's share of program costs are derived from earmarked funds made available for title XIX purposes through biennial appropriation by the State legislature. Unobligated balance may not be carried over to the next biennium but reverts to the General Fund.
<b>4. Deficit Financing</b>	When additional funds are needed before the next appropriation period, the Governor, through a special request to the State Legislature, can make additional funds available to offset a deficit.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Social Welfare

January 1, 1970

VERMONT

**A. General Information**

<b>1. Legal Base</b>	Title 33, Vermont Statutes Annotated, Section 2901, as amended by the 1967 Session of the General Assembly.
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on November 15, 1966.
<b>3. Administrative Responsibility</b>	The Vermont Department of Social Welfare serves as the single State agency with responsibility for administering the program on a Statewide basis. Within the Department, the Division of Medical Care Services carries major responsibility for program policy development and Statewide administration, and the Division of Family Services carries responsibility for eligibility determination. Activities of the Division of Medical Care Services are administered Statewide from the State Office, while those of the Division of Family Services are carried out through a system of 12 district offices.
<b>4. Historical Background</b>	The use of vendor payments for nursing home care and for limited hospitalization and physicians' services, first made in Vermont in January 1960 on behalf of OAA recipients, was extended in 1963 to provide the same services for blind and disabled recipients. Based on legislation enacted in 1961, a Federal-State program of Medical Assistance for the Aged (MAA) was instituted in January 1964 which provided limited hospitalization and physicians' services for persons age 65 or older who were not recipients of public assistance but who met certain prescribed conditions of financial and medical need. Medical and remedial care for AFDC recipients was provided only through inclusion of an amount in the monthly money payment and was subject to an overall dollar maximum on the total amount of the payment. This limited use of vendor payments for medical care continued with only minor changes until implementation of the State's present program under title XIX.
<b>5. Scope of Coverage</b>	Program provides for coverage of both categorically and medically needy persons. (See Items C.3 and C.4., below.)
<b>6. Differences in Scope of Services Provided</b>	Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:  Services for persons in institutions for mental diseases are provided only for patients who are 65 years of age or older.

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>b. In Institutions for Tuberculosis</b>	Not provided.  [There are no institutions for tuberculosis in Vermont.]
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older who are patients in public or private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost in accordance with agreement with State Department of Mental Health. Claims processed and paid by State Department of Social Welfare.
<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charge. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).

**B. Medical and Remedial Care and Services (Continued)**

<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>4. Skilled Nursing Home Services</b>	
a. General	Provided for persons of all ages. No limitations. Prior authorization required from State office Medical Consultant for services continuing beyond 30 days. Reimbursement on basis of rate recommended for each home by Advisory Rate Setting Committee based on cost. Claims processed and paid by State Department of Social Welfare.
b. In Institutions for Tuberculosis	Not provided.  [There are no institutions for tuberculosis in Vermont.]
c. In Institutions for Mental Diseases	Provided for persons age 65 or older who are patients in public and private institutions. [In Vermont, the two institutions used are the Vermont State Hospital and the Brattleboro Retreat, a private institution.] No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost in accordance with agreement with State Department of Mental Health. Claims processed and paid by State Department of Social Welfare.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. Experimental procedures excluded, and out-of-hospital physician's services for mental, psychoneurotic, or personality disorders limited to \$500 per year. No requirements for prior authorization. Reimbursement on basis of usual and customary charge. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>7. Services of Licensed Practitioners</b>	
a. Podiatrists	Provided. Limited to non-routine foot care, as provided in title XVIII - Part B. No requirements for prior authorization. Reimbursement on basis of usual and customary charge (as paid under Medicare). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
b. Chiropractors	Not provided.
c. Optometrists	Not provided.
d. Other	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided when furnished by a home health agency. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (title XVIII formula). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).</p> <p>(b) Services of home health aide. Provided when furnished by home health agency. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (title XVIII formula). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (title XVIII formula). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	Provided. Limited to physician-directed mental health clinics. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>11. Dental Services</b>	Not provided.  [Payments are made, however to Doctors of Dental Medicine and Doctors of Dental Surgery for major dental surgery of the kind covered by the Medicare program.]
<b>12. Physical Therapy and Related Services</b>	
<b>a. Physical Therapy</b>	Provided. When furnished through hospitals, nursing homes, or home health agencies. No payments to private practicing therapists. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (title XVIII formula). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>b. Occupational Therapy</b>	Provided. When furnished through hospitals, nursing homes, or home health agencies. No payments to private practicing therapists. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (title XVIII formula). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>c. Speech Therapy</b>	Provided. When furnished through hospitals, nursing homes, or home health agencies. No payments to private practicing therapists. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (title XVIII formula). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>d. Audiology</b>	Not provided.
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs, except supplement vitamins not included. No other limitations. Prior authorization required for therapeutic vitamins, cathartics, analgesics, and fecal softeners. Legend drugs reimbursed on basis of pricing formula, i.e., acquisition cost to providers plus professional fee. Non-legend drugs reimbursed on basis of pricing formula or usual charge, whichever is less. Claims processed by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Not provided.
<b>b. Hearing Aids</b>	Not provided.
<b>c. Dentures</b>	Not provided.
<b>d. Other Prosthetic Devices</b>	Provided. Limited to prosthetic devices, braces, and artificial limbs and eyes, as provided under the Medicare program. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charge (title XVIII formula). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices. No limitations. No requirements for prior authorization. Reimbursement of physician on basis of usual and customary charge; of pharmacists on basis of drug pricing formula (see Item B.13). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>16. Services of Christian Science Nurses</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided under same conditions as appertain to provision of such service under title XVIII program. No other limitations. No requirements for prior authorization. Reimbursement on basis of title XVIII reasonable cost standard. Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
a. Ambulance	Provided under same conditions appertaining in title XVIII program. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charge (title XVIII formula). Claims processed and paid by fiscal agent (New Hampshire-Vermont Hospitalization Service and Physician Service).
b. Other	Not provided.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility, an individual is retroactively entitled to assistance as early as the first day of the third month preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
a. Under Age 21	(1) Individual under age 21.
b. Age 21 to 64	<p>(1) Parent or caretaker relative (as specified in AFDC plan) with whom a child deprived of parental support or care is living.  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse (title XIX definition) of a recipient of AABD.</p>
c. Age 65 or older	(1) Individual who has attained age 65.



### C. Eligibility for Medical Assistance (Continued)

3. Coverage of the Categorically Needy	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
a. FFP Claimed in Medical and Administrative Costs	<p style="text-align: center;"><i>Mandatory</i></p>
	<p>(1) Recipients of AABD and AFDC.</p> <p>(2) Persons who would be eligible for AABD or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under age 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p>
b. FFP Claimed in Administrative Costs Only	<p style="text-align: center;"><i>Optional</i></p>
	<p>(4) Persons eligible for but not receiving AABD or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's AABD or AFDC program but who would be eligible for such assistance if they left the facility.</p> <p>(6) Parents or caretaker relatives (as defined in the State's AFDC plan) with whom dependent children described in Item C.3.a.(3), above are living.</p> <p>(7) All individuals under 21.</p> <p>(8) Essential spouse [title XIX definition] of a recipient of AABD. (Categorically needy only)</p>
4. Coverage of the Medically Needy	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a.(1) through (7), above, whose income and resources exceed the levels established under the State's plans for AABD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.</p>
5. Financial Criteria	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p>
a. For Categorically Needy Persons	<p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>b. For Medically Needy Persons</b>	<p><b>(1) Income</b></p> <p>Net annual income (computed in accordance with public assistance policies for earned and unearned income) which may be retained for basic maintenance needs: \$1740 for one person, \$2460 for family of 2, \$3000 for 3, \$3420 for 4, \$3900 for 5, \$4380 for 6, and \$420 for each additional member of the family household.</p> <p>Person in long-term care in a medical facility may retain \$9 a month for personal expenses. Additional income may be applied to maintenance needs of dependents up to \$1740 annually for one dependent, \$2460 for 2 dependents, and higher amounts for additional dependents (according to progression stated in preceding paragraph.)</p> <p><b>(2) Resources</b></p> <p>Real property used as a home may be retained regardless of value or equity.</p> <p>Non-home real property may be retained up to \$3000.</p> <p>The following personal property is exempt regardless of value: Personal effects, household furnishings, livestock, machinery, and an automobile.</p> <p>Cash value of life insurance with a face value up to \$3000 for one person, plus additional \$1000 face value for each additional person, is excluded in determining value of resources.</p> <p>Other real and personal property, such as cash, liquid assets, stocks and bonds, may be held up to a combined maximum value of \$900 for one person, \$1800 for 2 persons, \$2100 for 3 persons, plus \$300 for each additional person. (Value of non-home real property and of life insurance in excess of permissible amounts described above are included in these maximums.)</p> <p>Resources in excess of these exemptions and allowable maximums render an individual ineligible.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants or recipients of medical assistance is limited to the responsibility of spouse for spouse, and of parents for children under age 21.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>Medical Assistance Identification Cards are issued from the district office to each individual certified as a non-money payment recipient under the program. Cards are issued from the State office to each individual certified as a money payment recipient under the program. Through code number on each card, there is separate identification of money payment recipients (according to category of assistance) and non-money payment recipients.</p>

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Division of Medical Care Services (medical assistance unit) is one of the four major program divisions of the State Department of Social Welfare. The Director of the Division qualifies through academic training in public administration and substantial experience in the administration of a recognized medical care program. Other full-time professional staff of the Division consist of two Field Coordinators (social work), Medical Social Work Consultant (MSW), a Psychiatric Social Work Consultant (MSW), a Social Worker, and Registered Nurse. This staff is supplemented by the part-time services of four Medical Consultants (physician, psychiatrist, ophthalmologist, and pharmacist).</p>
<b>2. Supervision of Statewide Operations</b>	<p>Field operations of the Division of Medical Care Services are administered Statewide from the State office.</p> <p>Field operations of the Division of Family Services, which is responsible for the determination of eligibility, are carried out through a system of 12 district offices.</p>
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Advisory Council on Medical Programs. It is composed of 15 members appointed by the Commissioner of Social Welfare and has no ex officio members. Authority for the Council is administrative.</p>



**D. Administration and Management (Continued)**

<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Social Welfare processes and pays all vendor claims for services provided to eligible recipients in skilled nursing homes and in institutions for mental diseases.
<b>b. Fiscal Agents</b>	Blue Cross-Blue Shield (New Hampshire-Vermont Hospitalization Service and New Hampshire-Vermont Physician Service) serves as fiscal agent for the State Department of Social Welfare. Under terms of the contract, the fiscal agent processes and pays all vendor claims except those from skilled nursing homes and institutions for mental diseases.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Vermont as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/31/71 is 64.96.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from funds appropriated by the General Assembly on an annual basis for each fiscal year of the biennium. The unexpended balance of any appropriation reverts to the General Fund at the end of each fiscal year, unless otherwise specifically provided in the Appropriation Act.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If additional funds are needed before the next appropriation period, the program must be curtailed or a special session of the legislature must be called to appropriate additional funds.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health

January 1, 1970

VIRGIN ISLANDS

**A. General Information**

<b>1. Legal Base</b>	Executive Order of the Governor of the Virgin Islands No. 86-1966, and cited legal authority: 3 Virgin Islands Code—Section 67; 3 Virgin Islands Code—Section 418(a)(4); and 19 Virgin Islands Code—Section 272, 277 and 278.
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on November 15, 1966.
<b>3. Administrative Responsibility</b>	<p>The Department of Health serves as the single State agency with responsibility for administering the program on an island-wide basis through a system of local offices. The Bureau of Health Insurance and Medical Assistance, within the Department, implements the Plan's administration.</p> <p>Responsibility for determination of eligibility and other related functions is placed with the Department of Social Welfare which administers the public assistance programs; but the standards, rules, regulations, and policies for Medical Assistance are established by the Department of Health. There is a written agreement between the Department of Health and the Department of Social Welfare.</p>
<b>4. Historical Background</b>	<p>In the Islands the primary responsibility for medical care for indigent and medically indigent persons has rested, by statute, with the Insular Department of Health. The Department of Social Welfare made some vendor payments to suppliers of prescribed drugs and prosthetic appliances as early as 1951 for recipients of public assistance to supplement the services available through the Department of Health. In April 1955 a "pooled fund" system was developed as a fiscal convenience, but the scope of services remained the same for recipients of OAA, AB, APTD, and AFDC.</p> <p>Legislation enacted in 1960 placed responsibility for medical care of persons age 65 and older on the Department of Social Welfare and authorized that Department to contract with the Department of Health for the medical services required. The Department of Health under the contract was responsible for the medical aspects of the program. This legislation affected medical care under the OAA program by increasing the scope of services to inpatient hospital care, nursing home care, physicians' services, prescribed drugs, dental services, special duty nursing services, outpatient services, laboratory and X-ray services, transportation, medical supplies and equipment, and rehabilitative or restorative services. It also inaugurated, effective January 1, 1961, the Federal-State program of Medical Assistance for the Aged, for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. The scope of services for patients under this program was the same as for recipients of OAA except that nursing home care was not provided as such. All providers of services were those on the staff of the Department of Health and its facilities or under contract to that Department.</p> <p>Recipients of assistance under AB, APTD, and AFDC continued to receive only prescribed drugs and certain prosthetic appliances through the Department of Social Welfare vendor payments to providers of such services until the beginning of the title XIX program in July 1966.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exception:</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p> <p>[Note: At present, there are no nursing homes, as such, available; however, this service is provided at the hospitals.]</p>



**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to care in public facilities operated by Department of Health, except that, with prior authorization by State agency's Bureau of Health Insurance and Medical Assistance patient may be referred to or transferred to a hospital outside the Virgin Islands. Prior authorization by State agency's Bureau of Health Insurance and Medical Assistance required when hospitalization is for purpose of cosmetic surgery. Reimbursement on basis of reasonable cost. Claims processed and paid by Department of Health.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. Limited to services provided by Health Department facilities and personnel, except that, with prior authorization by State agency's Bureau of Health Insurance and Medical Assistance patient may be referred to or transferred to a hospital outside the Virgin Islands. Prior authorization by State agency's Bureau of Health Insurance and Medical Assistance required for surgical procedures for cosmetic purposes other than emergency repair or accidental injury. Reimbursement on basis of fee schedule approved by Legislature. Claims processed and paid by Department of Health.</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. Limited to services provided by Health Department facilities and personnel, or other approved Virgin Islands Laboratory when test service not available in the health facility. No requirements for prior authorization. Reimbursement on basis of fee schedule and customary and prevailing charges. Claims processed and paid by Department of Health.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to persons age 21 or older and to services provided by Health Department facilities and personnel for a maximum of 12 months per illness. Prior authorization by State agency's Bureau of Health Insurance and Medical Assistance required for initial 6-month period, with further approval of extension not to exceed an additional 6-month period. (At present there are no nursing homes, as such; but this kind of service is available at the hospitals.) Reimbursement on basis of negotiated rate not to exceed Medicare level of payment. Claims processed and paid by Department of Health.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. Limited to services provided by Health Department personnel, except that by prior authorization by State agency's Bureau of Health Insurance and Medical Assistance referral of patient may be made to physician practicing outside the Virgin Islands. Reimbursement of Health Department facilities and staff physicians on basis of fee schedule approved by Legislature; of private practicing physicians on basis of usual, customary, and prevailing charges as determined by Social Security Administration for Medicare purposes. Claims processed and paid by Department of Health.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>  <b>b. Optometrists</b>  <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Provided. Limited to persons age 65 or older covered by State's buy-in agreement when allowable as a Medicare benefit. No requirements for prior authorization. Reimbursement on basis of usual, customary, and prevailing charges. Claims processed and paid by Department of Health.</p> <p>Not provided. [Except: Payment is made for eyeglasses purchased from optometrists. See Item B.14.a.]</p> <p>Not provided.</p> <p>Not provided.</p>
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipients while at home:</p> <p>(a) Intermittent or part-time nursing services. Provided. Limited to services of nurses and other staff of the Home Health Service Division of the Health Department. No requirements for prior authorization, but all cases are reviewed at least once a month by Home Health Care Committee. Reimbursement on basis of fee schedule approved by Legislature. Claims processed and paid by Department of Health.</p> <p>(b) Services of home health aide. Provided. Limited to services of staff of the Home Health Service Division of the Health Department. No requirements for prior authorization, but all cases are reviewed at least once a month by Home Health Care Committee. Reimbursement on basis of fee schedule approved by Legislature. Claims processed and paid by Department of Health.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations, but may be obtained from private pharmacy only if not available through a Health Department facility. Prior authorization by State agency's Bureau of Health Insurance and Medical Assistance required. Reimbursement on basis of usual and customary charges. Claims processed and paid by Department of Health.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. Limited to services provided by facilities and professional staff of the Health Department except that by prior authorization by State agency's Bureau of Health Insurance and Medical Assistance, clinic services outside the Virgin Islands may be used. Reimbursement on basis of Virgin Islands fee schedule. Claims processed and paid by Department of Health.</p>
<b>11. Dental Services</b>	<p>Provided. Including orthodontia. Limited to services provided by facilities and professional staff of the Health Department. Prior authorization by State agency's Bureau of Health Insurance and Medical Assistance required for certain specified dental services. Reimbursement on basis of fee schedule approved by the Legislature. Claims processed and paid by Department of Health.</p>
<b>12. Physical Therapy and Related Services</b>  <b>a. Physical Therapy</b>  <b>b. Occupational Therapy</b>	<p>Provided. Limited to services provided by Health Department facilities and professional staff. (Limitation not applicable to services received by recipients age 65 or older when allowable as a Medicare benefit.) No requirements for prior authorization. Reimbursement on basis of fee schedule approved by Legislature. Claims processed and paid by Department of Health.</p> <p>Provided. Limited to services provided by Health Department facilities and professional staff. (Limitation not applicable to services received by recipients age 65 or older when allowable as a Medicare benefit.) No requirements for prior authorization. Reimbursement on basis of fee schedule approved by Legislature. Claims processed and paid by Department of Health.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>c. Speech Therapy</b>	Provided. Limited to services provided by Health Department facilities and professional staff. (Limitation not applicable to services received by recipients age 65 or older when allowable as a Medicare benefit.) No requirements for prior authorization. Reimbursement on basis of fee schedule approved by Legislature. Claims processed and paid by Department of Health.
<b>d. Audiology</b>	Provided. Limited to services provided by Health Department facilities and professional staff. No requirements for prior authorization. Reimbursement on basis of fee schedule approved by Legislature. Claims processed and paid by Department of Health.
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs. As furnished, at option of recipient, by a Health Department facility pharmacy or by a licensed pharmacist who has entered into an agreement with the State agency. Only generic names are honored. No other limitations. No requirements for prior authorization. Reimbursement to private pharmacies on basis of cost (actual cost of drug to pharmacist) plus a dispensing fee of \$1.50. Compensation for drugs furnished by Health Department facilities is either included in a reimbursement formula or paid in accordance with governmental statutes and regulations governing bulk purchases. Claims processed and paid by Department of Health.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. No limitations. No requirements for prior authorization. Payments made to private practicing optometrists having an agreement with the Department of Health. Reimbursement on basis of negotiated rate. Claims processed and paid by Department of Health.
<b>b. Hearing Aids</b>	Provided. In accordance with medical prescription. No limitations. Prior authorization by State agency's Bureau of Health Insurance and Medical Assistance required. Provided either directly by a Health Department facility or by direct purchase on behalf of recipient. Reimbursement on basis of customary rates. Claims processed and paid by Department of Health.
<b>c. Dentures</b>	Provided. No limitations. Prior authorization by State agency's Bureau of Health Insurance and Medical Assistance required. Furnished either directly by a Health Department facility or by direct purchase on behalf of recipient. Reimbursement on basis of customary rates. Claims processed and paid by Department of Health.
<b>d. Other Prosthetic Devices</b>	Provided. Replacement, corrective, or supportive devices, including orthopedic shoes, prescribed by a physician or other licensed practitioner for purpose of artificially replacing a missing part of the body, to prevent or correct a physical deformity or malfunction, or to support a weak or deformed part of the body. No limitations. Prior authorization by State agency's Bureau of Health Insurance and Medical Assistance required. Furnished either directly by a Health Department facility or by direct purchase on behalf of recipient. (Restriction on provider utilized not applicable to items received by recipients age 65 or older when allowable as a Medicare benefit.) Reimbursement on basis of customary rates. Claims processed and paid by Department of Health.
<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices, when under supervision of a physician. Physicians' services limited to those provided in a Health Department facility or by professional staff of the Health Department. Drugs, supplies, and devices limited to those provided by the pharmacy of a Health Department facility or by a private practicing pharmacist having an agreement with the Health Department. No other limitations, except that a service other than those specified (e.g., an operation) will be considered by the Bureau's Medical Consultant only on a referral basis, and subject to prior authorization from the Bureau of Health Insurance and Medical Assistance. Basis of reimbursement variable according to provider utilized. Claims processed and paid by Department of Health.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)	Not provided.
19. Personal Care Services In Patient's Home	Not provided.
20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services	Not provided.
21. Transportation	
a. Ambulance	Provided. No limitations. Prior authorization by State agency's Bureau of Health Insurance and Medical Assistance required except for emergencies and in critical situations where patient urgently needs access to medical care or facility. (Requirement for prior authorization not applicable to services received by recipients age 65 or older when allowable as a Medicare benefit.) Reimbursement on basis of fee schedule approved by Legislature, and usual, customary, or prevailing charge when rendered outside the Virgin Islands. Claims processed and paid by Department of Health.
b. Other	Provided. Transportation by taxicab, common carrier, airplane, or other appropriate means; including cost of means and lodging enroute, and cost of an attendant (meals, lodgings, and salary) if medically or otherwise necessary. Prior authorization by State agency's Bureau of Health Insurance and Medical Assistance required except for emergencies and critical situations where patient urgently needs access to medical care or facility. Reimbursement on basis of customary or prevailing charge. Claims processed and paid by Department of Health.

**C. Eligibility for Medical Assistance**

1. Date of Entitlement	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the third month prior to the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
2. Conditions of Eligibility (By Age Groups)	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.;
a. Under Age 21	(1) Individual under age 21.
b. Age 21 to 64	(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.  (2) Person who is blind (State definition).  (3) Person who is permanently and totally disabled (State definition).  (4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.
c. Age 65 or older	(1) Individual who has attained age 65.



## C. Eligibility for Medical Assistance (Continued)

<p><b>3. Coverage of the Categorically Needy</b></p> <p><b>a. FFP Claimed in Medical and Administrative Costs</b></p> <p><b>b. FFP Claimed in Administrative Costs Only</b></p>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(7) All individuals under age 21.</p> <p>(8) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only.)</p> <p style="text-align: center;"><i>Optional</i></p> <p>(1) Other individuals and families not related to the public assistance categories and not otherwise covered by the plan for Medical Assistance who apply for medical care at public expense.</p>
<p><b>4. Coverage of the Medically Needy</b></p>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a. and b., above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.</p>
<p><b>5. Financial Criteria</b></p> <p><b>a. For Categorically Needy Persons</b></p>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>

### C. Eligibility for Medically Assistance (Continued)

<p><b>b. For Medically Needy Persons</b></p>	<p>(1) <i>Income</i> Annual income which may be retained for basic maintenance needs: \$2200 for one person, \$2750 for family of 2, \$3190 for 3, \$3630 for 4, and \$440 for each additional member of the family household.</p> <p>(2) <i>Resources</i> Real property used as a homestead is exempt regardless of value. Other real property may be retained up to an assessed value of \$10,000.</p> <p>The following personal property is exempt regardless of value: Household effects, furniture, personal property, and an automobile essential to travel.</p> <p>Cash and personal assets convertible to cash (e.g., bank accounts, securities, savings, and cash surrender value of life insurance) may be retained up to \$1500 for one person plus \$100 for each additional person in the family.</p> <p>Ownership of resources in excess of allowable amounts precludes eligibility.</p>
<p><b>6. Financial Responsibility of Relatives</b></p>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21 or blind or permanently and totally disabled.</p>
<p><b>7. Identification to Vendors of Persons Eligible</b></p>	<p>An imprinted plastic Identification Card is issued to each individual and to all members of the family unit certified as eligible. Cards are prepared at each Certification Unit, using the document MA-1 ("Application and Certification").</p> <p>The face of the card shows the district, category, family number and individual number, name and address of recipient, date of birth, and expiration date. The back of the card carries instructions as to use of the Identification Card. The Identification Card is generally valid for one year. However, certification can be limited to a 3–6 month period, when anticipated changes are known. The card is reissued at the recertification period. A new one is given if changes have occurred; if there is no change of information, the new expiration date is added. Same type of card and procedures are used for all groups covered under the program. For applicant with excess income, a temporary card is issued when the excess has been used and the individual is in need of medical care; card covers him while eligible and in need.</p>

### D. Administration and Management

<p><b>1. Medical Assistance Unit</b></p>	<p>The Bureau of Health Insurance and Medical Assistance in the Department of Health is the medical assistance unit for the title XIX program. The Director (social worker, ACSW) is directly responsible to the Commissioner of Health. The other full-time staff of the Bureau consists of a Chief of Research and Statistics, a Chief of Quality Control, a Medical Social Worker, 2 Family Service Workers, and 4 statistical clerks. In addition there are 5 consultants who devote part time to the program: a medical consultant, dental consultant, pharmaceutical consultant, nursing consultant and special education consultant.</p>
<p><b>2. Supervision of Statewide Operations</b></p>	<p>Supervision of medical aspects of Statewide operations is accomplished through the staff identified above in Item 1.</p> <p>Supervision of the eligibility and related aspects, Statewide, is accomplished through the Director of Assistance Payments and Adult Services, in the Department of Social Welfare, and the regular field staff of the agency.</p>
<p><b>3. Advisory Council</b></p>	<p>The State advisory body for title XIX is known as the Medical Assistance Advisory Committee. It is composed of 12 members appointed by the Governor. There are 2 ex officio members: the Commissioner of Health and the Director of the Bureau of Health Insurance and Medical Assistance. Authority for the Committee is administrative.</p>



**D. Administration and Management (Continued)**

<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all title XIX recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	All phases of the claims payment process are handled directly by personnel of the State agency.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for the Virgin Islands as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.00.
<b>2. State/Local Participation</b>	Insular funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually for all health programs from which an allotment is made for the title XIX program. Unobligated balance may not be carried over at the end of the fiscal year but reverts to the main account.
<b>4. Deficit Financing</b>	There is no authority for deficit financing. If it is estimated that the total obligation of the Islands' share is insufficient, a reprogramming of funds may be authorized by the Commissioner. If this is not possible, a recommendation will be made to the Office of the Budget for additional funds.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health

January 1, 1970

VIRGINIA

## A. General Information

1. Legal Base	Section 32-30.1, Code of Virginia, as amended by the 1968 Acts of the General Assembly of Virginia.
2. Beginning Dates	Program went into operation on July 1, 1969. Original plan approved by the Federal agency on June 18, 1969.
3. Administrative Responsibility	<p>The Department of Health serves as the single State agency with responsibility for administering the program on a Statewide basis.</p> <p>The determination of eligibility is made by the city and county departments of public welfare under the supervision of the State Department of Welfare and Institutions for recipients of OAA, APTD, or AFDC or medically needy persons categorically related to these programs and for children in foster care; and under the supervision of the State Commission for the Visually Handicapped for recipients of AB or medically needy persons categorically related to that program.</p>
4. Historical Background	<p>Provisions for vendor payment of the costs of medical care with Federal financial participation as a part of the public assistance programs began in August 1958 with nursing home care for recipients of OAA, AB, and APTD. In 1960, legislation authorized vendor payments for inpatient hospital services for these three categories and for AFDC. All other kinds of medical care recognized by the State as special needs were included in the money payment to the recipient along with maintenance needs.</p> <p>In January 1964 a Federal-State program of Medical Assistance for the Aged (MAA) began for persons age 65 and older who were not recipients of OAA but who met certain criteria of medical and financial need. The scope of services included inpatient hospital care, post-hospital nursing home care, physicians' services, dental care, prescribed drugs, and outpatient hospital and clinic care. All of these, except the first two, were subject to a provision that the applicant was responsible for the first \$25 of expenses incurred for one or a combination of any of the services within 3 months prior to date of application or later.</p> <p>When Medicare (title XVIII) went into effect, as of July 1, 1966, the State modified the services under OAA to take full advantage of enrollment of aged recipients in Part A and, under the "buy-in" agreement, in Part B of Medicare. They also developed a contract with Blue Cross-Blue Shield of Virginia for payment of the deductibles and coinsurance and costs of certain minor outpatient services for enrolled OAA recipients and for those who were not eligible for Medicare. Vendor payments were continued under the public assistance titles for nursing home care not covered under Medicare. The State continued to include in the money payment allowances for drugs, dental care, and medical supplies which were not included in Medicare for OAA recipients or were needed by recipients of AB, APTD, and AFDC who were not eligible for enrollment. The MAA program was also modified to correlate its services with those available under Medicare and the supplementation needed for persons not eligible for enrollment. These programs continued until the Medicaid (title XIX) program began.</p>
5. Scope of Coverage	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services provided for categorically needy persons are not made available to medically needy persons (Items B.14.a., B.21.b.).</p> <p>Certain services provided for categorically needy persons are made available only to those medically needy persons who are covered by the State's buy-in agreement (Items B.8.(c), B.14.d.).</p>



**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Ward or private accommodations; private room when ordered by physician as medically necessary. Physician's certification and later recertification as to medical necessity required. No limitations. No requirements as to prior authorization. Payment only to hospitals which have entered into participation agreement with State agency. Reimbursement on basis of reasonable cost (according to Medicare principles and standards). Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p> <p>Provided. Limited to persons age 65 or older in State-operated institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (according to Medicare principles and standards). Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p> <p>Provided. Limited to persons age 65 or older in State-operated institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost (according to Medicare principles and standards). Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. Must be furnished by or under direction of physician. No limitations. No requirements for prior authorization. Payment only to hospitals which have entered into participation agreement with State agency. Reimbursement on basis of reasonable cost (according to Medicare principles and standards). Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. Limited to diagnostic laboratory services ordered by a physician. No requirements for prior authorization. Reimbursement on basis of usual and customary charges. Payment only to independent laboratory certified by State agency which has entered into a participation agreement with State agency. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. For persons of all ages. Semi-private accommodations; private room only when ordered by physician as medical necessity. No limitations. Prior authorization by State agency required for care beyond first 180 consecutive days or 180 days during a calendar year. Payment only to providers which have entered into a participation agreement with State agency. Reimbursement on basis of reasonable cost, following same principles and standards applicable to Medicare. (Monthly payment at interim per diem rate established for each facility at most prevalent rate for semi-private accommodations; cost settlement at year end for adjustment to reasonable cost, after fiscal agent audit of facility's actual financial statement). Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p> <p>Not provided.</p> <p>Not provided.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>As provided in the regulations of the Secretary of the U.S. Department of Health, Education, and Welfare. Presently limited to screening (one examination annually) of children in foster care.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. Excluding immunizations and routine physical examinations (except for foster children). No other limitations. No requirements for prior authorization. Payment only to providers who have entered into a participation agreement with State agency. Reimbursement on basis of usual, customary, and reasonable charges, but not to exceed limits of schedule of allowances as established July 1969. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>7. Services of Licensed Practitioners</b>	
a. Podiatrists	Provided. As ordered by a physician in accordance with a plan of treatment. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).
b. Optometrists	Provided. One refraction per year; one pair of glasses per year. Prior authorization by local health department required for each service; also required for repair of glasses. Reimbursement on basis of usual, customary, and reasonable charges. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).
c. Chiropractors	Not provided.
d. Other	Not provided.
<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. As ordered by a physician and furnished by a home health agency in accordance with plan for treatment. Prior authorization by local health department required; also, review and progress report required to justify continuation of agency visits beyond 90 days. Except that prior authorization, review, and progress report are not required for services received as Medicare benefits by persons covered by State's buy-in agreement. Payment made only to providers who have entered into a participation agreement with State agency. Reimbursement on basis of reasonable costs. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p> <p>(b) Services of home health aide. Provided. As ordered by a physician and furnished by a home health agency in accordance with a plan for treatment. Prior authorization by local health department required; also, review and progress report required to justify continuation of agency visits beyond 90 days. Except that prior authorization, review, and progress report are not required for services received as Medicare benefits by persons covered by State's buy-in agreement. Payment made only to providers who have entered into a participation agreement with State agency. Reimbursement on basis of reasonable costs. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p> <p>(c) Medical supplies, equipment, and appliances. Including rental or purchase of durable equipment. Provided for all categorically needy persons; for medically needy, limited to persons covered by State's buy-in agreement, when received as Medicare benefits. Prior authorization by local health department required except when furnished as Medicare benefit to persons covered by buy-in agreement. Payment made only to providers who have entered into participation agreement with State agency. Reimbursement on basis of usual, customary, and reasonable charges. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Not provided.</p> <p>[No payment direct to RN or LPN. But payment will be made direct to hospital for such service provided to a hospital inpatient if hospital engages services of nurse under an arrangement whereby billing will be made by the hospital.]</p>
<b>10. Clinic Services (Other than Hospital)</b>	Provided. As furnished by local health departments and general medical clinics. No limitations. No requirements for prior authorization. Payment made only to providers which have entered into participation agreement with State agency. Reimbursement on basis of reasonable cost (according to Medicare principles and standards). Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).
<b>11. Dental Services</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>12. Physical Therapy and Related Services</b>	
a. Physical Therapy	<p>Provided. No limitations. Authorization by local health department required when furnished by home health agency, with additional requirement for 90-day review and progress report when visits are to continue beyond 90 days. Except that such authorization is not required for services received as Medicare benefits by persons covered by State's buy-in agreement. Payment only to providers which have entered into participation agreement with State agency. No payment to physical therapists in private practice. Reimbursement on basis of reasonable costs. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p>
b. Occupational Therapy	<p>Provided. No limitations. Authorization by local health department required when furnished by home health agency, with additional requirement for 90-day review and progress report when visits are to continue beyond 90 days. Except that such authorization is not required for services received as Medicare benefits by persons covered by State's buy-in agreement. Payment only to providers which have entered into participation agreement with State agency. No payment to occupational therapists in private practice. Reimbursement on basis of reasonable costs. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p>
c. Speech Therapy	<p>Provided. No limitations. Authorization by local health department required when furnished by home health agency, with additional requirement for 90-day review and progress report when visits are to continue beyond 90 days. Except that such authorization is not required for services received as Medicare benefits by persons covered by State's buy-in agreement. Payment only to providers which have entered into participation agreement with State agency. No reimbursement to speech therapists in private practice. Reimbursement on basis of reasonable costs. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p>
d. Audiology	Not provided.
<b>13. Prescribed Drugs</b>	<p>Provided. Legend (including insulin and oral contraceptives) and non-legend drugs within the therapeutic classes of antacids, cough and cold preparation, dermatologies, hemorrhoid preparations, internal analgesics, laxatives, vitamins and hematinics, and family planning supplies. Legend drugs are limited to the original and up to 2 refills within a 90-day period from the date the original prescription was written; non-legend drugs may not be refilled. Reimbursement for legend drugs, including compounds, on the basis of actual acquisition cost of the drugs plus a fee of \$1.80; for non-legend drugs, insulin, and oral contraceptives on the basis of usual and customary retail charge.</p>
<b>14. Prosthetic Devices</b>	
a. Eyeglasses	<p>Provided. For categorically needy persons only. Limited to one pair of eyeglasses per year; frames for cosmetic purposes and sunglasses are excluded. No other limitations. Prior authorization by local health department required for new glasses and for repair or replacement of frames and lenses. Payment made only to providers who have entered into participation agreement with State agency. Reimbursement on basis of usual, customary, and reasonable charges. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p>
b. Hearing Aids	Not provided.
c. Dentures	Not provided.
d. Other Prosthetic Devices	<p>Provided. Consisting of replacement, corrective and supportive devices; includes prostheses (except dental) to replace all or part of a missing body part; orthopedic shoes and devices. Provided for all categorically needy persons; for medically needy, limited to persons covered by State's buy-in agreement, when received as Medicare benefits. Physician's prescription required. No other limitations. Prior authorization by local health department required except when furnished as Medicare benefits to persons covered by buy-in agreement. Payment made only to providers who have entered into participation agreement with State agency. Reimbursement on basis of usual, customary, and reasonable charges. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p>

**B. Medical and Remedial Care and Services (Continued)**

15. Family Planning Services	Provided. Including drugs, supplies, and devices. No limitations. No requirements for prior authorization. Payment made only to providers which have entered into a participation agreement with State agency. Reimbursement on variable basis according to type of provider. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).
16. Services of Christian Science Nurses	Not provided.
17. Care and Services in Christian Science Sanatoria	Not provided.
18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).
19. Personal Care Services in Patient's Home	Not provided.
20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services	Not provided.
21. Transportation  a. Ambulance          b. Other	<p>Provided. Unlimited for categorically needy persons. For medically needy, limited to emergencies and trips necessary to move patient to lower level of care. No other limitations. Prior authorization by local health department required for all non-emergency trips. Except for emergency services, payment made only to providers which have entered into participation agreement with State agency. Claims processed and paid by fiscal agent (Blue Cross of Virginia and Blue Shield of Virginia).</p> <p>Provided. For categorically needy persons only. Transportation by taxicab, bus, railroad, or other licensed commercial carriers for surface transportation. Including meals and lodgings enroute, and an attendant if required. No other limitations. Prior authorization by local health department required for each trip. Reimbursement on basis of public carrier rates, or as negotiated by the local health department. Claims processed and paid by the State Agency.</p>

**C. Eligibility for Medical Assistance**

1. Date of Entitlement	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the month in which application was made, provided all conditions of eligibility were met in the month in which services were rendered.
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## C. Eligibility for Medical Assistance (Continued)

2. Conditions of Eligibility (By Age Groups)	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a:
a. Under Age 21	<p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in foster home or private institution for whom a public agency is assuming financial responsibility in whole or in part. (Including non-AFDC foster care.)</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(6) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p>
b. Age 21 to 64	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p>
c. Age 65 or older	(1) Individual who has attained age 65.
3. Coverage of the Categorically Needy	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
a. FFP Claimed in Medical and Administrative Costs	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(7) All children under age 21 in foster homes or private institutions for whom public agencies have custody and are assuming financial responsibility in whole or in part.</p> <p>(8) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only.)</p>
b. FFP Claimed in Administrative Costs Only	<i>Optional</i>
	None.

## C. Eligibility for Medical Assistance (Continued)

4. Coverage of the Medically Needy	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a., above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with regulations.</p>
5. Financial Criteria	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p>
a. For Categorically Needy Persons	<p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p>
b. For Medically Needy Persons	<p>(1) <i>Income</i>  Income which may be retained for basic maintenance needs: \$1700 for one person, \$2200 for family of 2, \$2600 for 3, \$3000 for 4, and \$400 for each additional member of the family household. (Annual income.)</p> <p>Person in chronic (long-term) care in a medical facility may retain \$20 a month for personal expenses. Additional income may be applied to maintenance needs of dependents up to \$1700 a year for one dependent, \$2200 for 2 dependents, plus \$400 for each additional dependent.</p> <p>(2) <i>Resources</i>  Home used as a residence is exempt regardless of value.</p> <p>Income-producing real property may be retained if equity is under \$10,000; equity of \$10,000 or more precludes eligibility.</p> <p>Ownership of non-income-producing, non-home real property precludes eligibility unless (1) property cannot be sold, or (2) sale would involve undue financial sacrifice, or (3) market value of the property, when added to personal assets, does not exceed allowable amount of personal property described below.</p> <p>The following personal property is exempt: Personal effects, household furnishings, automobile, farm machinery and livestock, and property used in earning income.</p> <p>Other personal property (e.g., cash, savings, savings certificates, trust funds, and value of certain insurance) may be retained up to value of \$600 for one person, \$900 for 2 persons, plus \$100 for each additional person.</p> <p>Life insurance may be retained if face value of an individual policy is under \$5,000; if \$5,000 or more, cash value is considered an available asset.</p> <p>Burial insurance is considered an available asset at face value, if paid-up, or cash value if not paid up.</p> <p>Income and/or resources in excess of these amounts disqualify applicant from receiving medical assistance under the program until the applicant has "spent down" to the appropriate level, with income level computations based on the six-month increment initiating with month of application.</p>
6. Financial Responsibility of Relatives	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of husband for wife and of parents for children who are under age 17, or blind, or permanently and totally disabled.</p>



**C. Eligibility for Medical Assistance (Continued)**

<b>7. Identification to Vendors of Persons Eligible</b>	A Medical Assistance Program Identification Card is issued by the fiscal agent to each one-person and to each family unit certified as eligible, which is valid for a 6-month period. Face of card shows beginning and ending dates of eligibility, type of coverage (i.e., categorically needy or medically needy), case number, and name and identification number of each eligible member within the family unit. Coding on the card indicates whether insurance or other outside medical resources are available. Card is reissued automatically 6 months from date of entitlement and thereafter at 6-month intervals so long as eligibility continues. For applicant with excess income resources, card is valid from the day after "spend down" is achieved (see Item C.5.b.(2) above) to the end of the six-month increment period and is not renewed until eligibility is re-established.
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**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Virginia Medical Assistance Program is the name of the medical assistance unit in the Division of Medical and Hospital Services of the Department of Health. The Medical Director (M.D., M.P.H.) has a full-time professional staff of a Medical Assistance Program Administrator, 2 Program Representative Supervisors, 6 Program Field Representatives, a Medical Social Work Supervisor, a Medical Social Worker, a Public Welfare Supervisor, 4 Social Work Aides, an Accountant, a Statistician, and an Information Officer. There is also a part-time Advisor for Pharmacy Services and one for Psychiatric Services.								
<b>2. Supervision of Statewide Operations</b>	Supervision of Medical aspects of Statewide operations is accomplished through a staff of Program Field Representatives.  Supervision of the eligibility determination aspects of the program is accomplished through the regular field staff of the Department of Welfare and Institutions.								
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Governor's Advisory Committee on Medicare-Medicaid. It is composed of 13 members appointed by the Governor. There are 3 ex officio members (Director, Department of Welfare and Institutions; Commissioner, Department of Health; Commissioner, Department of Mental Hygiene and Hospitals). Authority for the Committee is administrative.								
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.								
<b>5. Claims Payment Process</b>	<table> <tr> <td data-bbox="140 1339 343 1392"><b>a. State and Local Agencies</b></td><td data-bbox="499 1339 1476 1423">The State agency fulfills its administrative responsibility for review and payment of claims through contract with fiscal agents to process and pay all claims except for non-ambulance transportation which is processed and paid by the State agency. (See sub-item b. below.)</td></tr> <tr> <td data-bbox="140 1455 320 1480"><b>b. Fiscal Agents</b></td><td data-bbox="499 1455 1540 1570">The Department of Health has entered into a contract with Blue Cross of Virginia and Blue Shield of Virginia (as one entity) to serve as fiscal agent to process and pay claims from providers of medical services, except for non-ambulance transportation which is processed and paid by the State agency.</td></tr> <tr> <td data-bbox="140 1602 323 1686"><b>c. Prepaid Capitation Arrangements</b></td><td data-bbox="499 1602 566 1627">None.</td></tr> <tr> <td data-bbox="140 1717 316 1801"><b>d. Payments to Non-Medical Institutions</b></td><td data-bbox="499 1717 566 1743">None.</td></tr> </table>	<b>a. State and Local Agencies</b>	The State agency fulfills its administrative responsibility for review and payment of claims through contract with fiscal agents to process and pay all claims except for non-ambulance transportation which is processed and paid by the State agency. (See sub-item b. below.)	<b>b. Fiscal Agents</b>	The Department of Health has entered into a contract with Blue Cross of Virginia and Blue Shield of Virginia (as one entity) to serve as fiscal agent to process and pay claims from providers of medical services, except for non-ambulance transportation which is processed and paid by the State agency.	<b>c. Prepaid Capitation Arrangements</b>	None.	<b>d. Payments to Non-Medical Institutions</b>	None.
<b>a. State and Local Agencies</b>	The State agency fulfills its administrative responsibility for review and payment of claims through contract with fiscal agents to process and pay all claims except for non-ambulance transportation which is processed and paid by the State agency. (See sub-item b. below.)								
<b>b. Fiscal Agents</b>	The Department of Health has entered into a contract with Blue Cross of Virginia and Blue Shield of Virginia (as one entity) to serve as fiscal agent to process and pay claims from providers of medical services, except for non-ambulance transportation which is processed and paid by the State agency.								
<b>c. Prepaid Capitation Arrangements</b>	None.								
<b>d. Payments to Non-Medical Institutions</b>	None.								

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**E. Financing**

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<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Virginia as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 65.04.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially. Unexpended balance may be carried over within the biennium but reverts to the General Fund at the end of the biennium.
<b>4. Deficit Financing</b>	Under exceptional circumstances, the Governor may authorize deficit financing. Otherwise, if additional funds are needed before the next appropriation period, the program must be curtailed.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Public Assistance

January 1, 1970

WASHINGTON

**A. General Information**

<b>1. Legal Base</b>	RCW 74.09.500 et seq.
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on June 28, 1966.
<b>3. Administrative Responsibility</b>	The State Department of Public Assistance serves as the single State agency with responsibility for administering the program on a Statewide basis through 35 local offices. In general, each local office serves one county. Some counties are served by more than one local office and some local offices serve more than one county.
<b>4. Historical Background</b>	<p>Payments for medical care under the Federal-State public assistance categories through vendor payments to the providers of such care began in July 1955. The statute provided for "needed medical, dental, and allied services to recipients of public assistance and medical indigents". Thus Washington was one of the few States at that time which paid for medical services needed by persons who met all eligibility requirements for one of the public assistance categories except the income level for maintenance and who needed help with the cost of medical care. The wide scope of services permitted under the law was implemented in the plan except that nursing home care was provided only through the money payment to recipients.</p> <p>In October 1960, Washington was one of the first States to implement the Federal-State program of Medical Assistance for the Aged (MAA), to provide medical care to persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. Although the program was implemented on the basis of the existing statute, further legislation specifically related to the MAA program was enacted in March 1963. At this time, the law transferred all long-term nursing home care for persons age 65 or older to the MAA program and permitted only "non-continuing nursing home care" not to exceed 30 days in duration under OAA, AB, APTD, and AFDC categories within the money payment to recipients. Some modification of these plans was made immediately prior to the implementation of title XIX on July 1, 1966.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for mental diseases are provided only for patients who are 65 years of age or older. (Item B.1.c.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. No limitations. Approval of local medical consultant required for hospital admission and stays beyond 14 days. Prior approval by Assistant Director required for elective surgery and stays beyond 30 days. Reimbursement on basis of charges related to cost. Claims processed and paid by State Department of Public Assistance.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older in public and private institutions. No other limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Public Assistance.

**B. Medical and Remedial Care and Services (Continued)**

<b>2. Outpatient Hospital Services</b>	Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges related to reasonable cost. Claims processed and paid by State Department of Public Assistance.
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. Prior authorization by local medical consultant required for allergy testing; by Assistant Director for X-ray therapy. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Assistance.
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. No limitations. Prior approval of State office required for initial placement of children under age 15; approval of local office for all others. Two levels of skilled nursing home care recognized; patients evaluated and classified according to level of care needed, and nursing homes classified according to level of care they are equipped to provide. Payment made only to homes which have signed a contract with State Department of Public Assistance. Reimbursement on basis of fixed per diem rate established by State Department (based on filed costs of all homes) for two levels of care. Claims processed and paid by State Department of Public Assistance.
<b>b. In Institutions for Tuberculosis</b>	Not provided.
<b>c. In Institutions for Mental Diseases</b>	Not provided.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	Not provided.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. Limited to one call per month for non-emergent conditions in the office, home, intermediate care facility, nursing home, or hospital outpatient departments; one call per day for hospitalized patients; two calls per month for treatment of new and acute conditions and in extended care facilities. Additional calls when justified in writing by the physician. All surgical procedures require authorization by local medical consultant; non-acute and emergent surgical procedures require prior approval by Assistant Director. Reimbursement on basis of local Medical Service Bureau fee schedule. Claims processed and paid by State Department of Public Assistance.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. No limitations, except that routine foot care is not authorized. No requirements for prior authorization. Reimbursement on basis of statewide fee schedule. Claims processed and paid by State Department of Public Assistance.
<b>b. Optometrists</b>	Provided. Limited to refractions and eyeglasses on a priority basis for persons with special health problems (e.g., cataracts and diabetes) and as an aid to persons in education status, in training programs, and in self-help situations. Prior approval from local office required. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Assistance.
<b>c. Chiropractors</b>	Not provided.
<b>d. Other</b>	Not provided.



**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. No limitations, but must be requested by attending physician. Prior authorization by nursing care consultant required for continuation of service beyond one month. Payments made to Title XVIII certified home health agencies on basis of fixed fee. Claims processed and paid by State Department of Public Assistance.</p> <p>(b) Services of home health aide. Provided. No limitations, but must be requested by attending physician. Prior authorization by nursing consultant required for continuation of service beyond one month. Payments made to title XVIII certified home health agencies on basis of fixed fee. Claims processed and paid by State Department of Public Assistance.</p> <p>(c) Medical supplies, equipment, and appliances. Provided. No limitations, but must be requested by attending physician. Prior authorization by local medical consultant, or nursing care consultant (depending on nature of request). Major equipment and appliances require prior approval by Assistant Director. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Assistance.</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Provided. Intermittent or part-time nursing in patient's home limited to situations where services of a home health agency are not available. Full-time nursing service limited to hospital inpatients, with requirement for prior approval by local medical consultant and Assistant Director. Reimbursement on basis of fixed fee. Claims processed and paid by State Department of Public Assistance.</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Not provided.</p>
<b>11. Dental Services</b>	<p>Provided. Orthodontia excluded. No other limitations. Basic services exceeding \$32 and all other services require prior authorization of treatment plan by Department Supervising Consulting Dentist. Payments made to dentists who have entered into written participation agreement with State Department of Public Assistance. Reimbursement on basis of Dental Care Program Schedule of benefits and maximums. Claims processed and paid by fiscal agent (Washington Dental Service).</p>
<b>12. Physical Therapy and Related Services</b>  <b>a. Physical Therapy</b>  <b>b. Occupational Therapy</b>  <b>c. Speech Therapy</b>  <b>d. Audiology</b>	<p>Provided. When administered as outpatient service of a hospital; to patients in nursing homes; to patients in own homes when provided by registered physical therapists. Prior authorization by local medical consultant required. Reimbursement on basis of fixed fee. Claims processed and paid by State Department of Public Assistance.</p> <p>Not provided.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>13. Prescribed Drugs</b>	<p>Provided. Legend and non-legend drugs, exclusive of common household drugs which can be purchased without a prescription. No other limitations. Prior authorization by local medical consultant required for non-formulary drugs and drugs listed in Department formulary costing more than \$15. Reimbursement on basis of cost plus 66 2/3%. Claims processed and paid by State Department of Public Assistance.</p>
<b>14. Prosthetic Devices</b>  <b>a. Eyeglasses</b>	<p>Provided. Limited, on priority basis as an aid to persons in educational or training programs, as an aid to self-help, and for persons with special health problems such as cataracts or diabetes. Prior authorization by local office required. Reimbursement on basis of Department price list. Claims processed and paid by State Department of Public Assistance.</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>b. Hearing Aids</b>	Not provided.  [State-owned hearing aids made available on a loan basis when sufficient hearing loss is present.]
<b>c. Dentures</b>	Provided. According to Dental Care Program Schedule of benefits and maximums. Prior authorization required by Department Supervising Consulting Dentist when cost exceeds \$32. Reimbursement on basis of Dental Care Program Schedule. Claims processed and paid by fiscal agent (Washington Dental Service).
<b>d. Other Prosthetic Devices</b>	Provided. Major and minor devices and appliances. No limitations. Prior approval required by local medical consultant for minor items; by Assistant Director for major items. Reimbursement on basis of usual and customary charges. Claims processed and paid by State Department of Public Assistance.
<b>15. Family Planning Services</b>	Provided. Including drugs, supplies, and devices. No limitations, but services must be under supervision of a physician. No requirements for prior authorization. Reimbursement on basis of fee schedule. Claims processed and paid by State Department of Public Assistance.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. No limitations. Prior authorization by nursing care consultant required. Payment only to institutions which have entered into contract with State Department. Reimbursement on basis of fixed per diem nursing home rate established by Department. Claims processed and paid by State Department of Public Assistance.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. For period necessary to prevent physical impairment or loss of life. No requirements for prior authorization. Reimbursement on basis of reasonable cost (as paid by Medicare). Claims processed and paid by State Department of Public Assistance.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. Excluding trips to mental hospital (after commitment) or tuberculosis hospital. Prior authorization by local office required for non-emergent condition, when transportation is from hospital to other than medical facility; by Assistant Director for out-of-State transportation. Reimbursement on basis of fixed rates established by Department of Public Assistance. Claims processed and paid by State Department of Public Assistance.
<b>b. Other</b>	Provided. Consisting of private transportation by relatives, friends, taxis, or common carrier. Transportation from home to doctor's office or other source of routine treatment limited to situations where public transportation is not available or patient is physically unable to make use of it. Excludes trips to mental hospital (after commitment) or tuberculosis hospital. Prior authorization by local office required for non-emergent condition, when transportation is from hospital to other than a medical facility; by Assistant Director for out-of-State transportation. Reimbursement of taxi and common carrier on basis of usual and customary rates; to relatives or friends on basis of cost, not to exceed 5¢ per mile. Claims processed and paid by State Department of Public Assistance.



### C. Eligibility for Medical Assistance

1. Date of Entitlement	Upon determination of eligibility an individual is entitled to assistance for medical services initiated as early as seven days prior to the date of application provided all conditions of eligibility were met as of the first day of coverage. If application is made after the seventh day from the day services were begun, entitlement date is day of application.
2. Conditions of Eligibility (By Age Groups)	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p> <p>a. Under Age 21</p> <p>(1) Individual under age 21.</p> <p>b. Age 21 to 64</p> <p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p>c. Age 65 or older</p> <p>(1) Individual who has attained age 65.</p>
3. Coverage of the Categorically Needy	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>a. FFP Claimed in Medical and Administrative Costs</p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) Caretaker relatives (as specified in the State's AFDC plan) with whom children described in Item C.3.a.(3), above, are living.</p> <p>(7) All individuals under age 21.</p> <p>(8) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only)</p> <p style="text-align: center;"><i>Optional</i></p> <p>b. FFP Claimed in Administrative Costs Only</p> <p>(1) Needy persons between the ages of 21 through 64 who are not categorically related under the State's approved plan for OAA, AB, APTD, or AFDC but who are recipients of continuing non-Federal aid grants.</p>

### C. Eligibility for Medical Assistance (Continued)

<b>4. Coverage of the Medically Needy</b>	<p>Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Item C.3.a., whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and/or resources above such levels is reduced by the dollar amount of the excess in accordance with regulations.</p>
<b>5. Financial Criteria</b>  <b>a. For Categorically Needy Persons</b>  <b>b. For Medically Needy Persons</b>	<p>The following criteria are used in establishing financial eligibility for medical assistance:</p> <p>Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.</p> <p><b>(1) Income</b></p> <p>Annual income which may be retained for basic maintenance needs: \$2340 for one person, \$3000 for family of 2, \$3780 for 3, \$4260 for 4, and \$480 for each additional member of the family household.</p> <p>Person in chronic (long-term) care in a medical facility may retain \$10 a month for personal expenses. Additional income may be applied to maintenance needs of dependents as shown in preceding paragraph.</p> <p><b>(2) Resources</b></p> <p>Real property used as a home may be retained, together with a reasonable amount of property surrounding and contiguous thereto which is used by and useful to the applicant.</p> <p>Other real property is not exempt unless applicant is unable to sell, rent, or lease the property at any price, in which case it is exempt pending any change which might give it value.</p> <p>The following personal property is exempt regardless of value: Used and useful household furnishings and personal clothing; items of great sentimental value; livestock or other similar property owned by a child for sole purpose of participating in an organized group or school activity, such as 4-H Club.</p> <p>Cash, marketable securities, cash surrender value of insurance, and equity value of an automobile (used and useful) may be retained up to \$750 for one person, \$1450 for family of two, plus \$50 for each additional family member. Within this overall limitation, the total amount of cash and marketable securities held may not exceed \$200 for one person, \$400 for a family of two, plus \$25 for each additional family member.</p> <p>Fair market value of resources in excess of these amounts do not render an individual ineligible, but excess must be applied to costs of medical care.</p>
<b>6. Financial Responsibility of Relatives</b>	<p>The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21.</p>
<b>7. Identification to Vendors of Persons Eligible</b>	<p>A Medical Care Identification Booklet, containing six detachable coupons, is issued to all eligible persons. A temporary booklet is issued initially by the local office; thereafter, on a monthly basis by the State office. Booklet is issued in name of an adult member of the family, lists names and birth dates of all eligible members of the family, and shows expiration date. When recipient has medical insurance which he must use, a brief statement to this effect appears on face of booklet. In cases involving excess income and resources, vendors are furnished a copy of recipient's Award Letter in which are shown amount of participation by recipient in cost of medical care and the period for which this arrangement is to be in effect. A copy of the Award Letter is sent to the Medical Audit Section as a control limiting the Department's payment according to the terms set forth therein.</p>



**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Assistant Director, Division of Medical Care (medical assistance unit), is directly responsible to the Director of the State Department of Public Assistance. In addition to the Assistant Director (M.D.), the full-time professional staff of the Division consists of a Supervisor, Medical Social Services Unit (MSW) and five Social Service Program Specialists; Supervisor, Medical Program and Planning Unit (M.A., Medical Care Administration), 8 Welfare Program Specialists and one Medical Services Administrative Representative; Supervisor, Nursing Unit (R.N., Master's degree), and 27 Nursing Care Consultants; 2 Medical Consultants (M.D.); a Pharmacy Consultant; and a Medical Service Administrative Assistant. This staff is supplemented by the part-time services of a Supervising Consulting Dentist (D.D.S.), a Consultant Psychiatrist (M.D.), and 33 Medical Consultants (M.D.'s).
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the supervisory and consultative staff listed in Item D.1. above in the Division of Medical Care.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Care Advisory Committee. It is composed of 12 members appointed by the Director of the State Department of Public Assistance. There are 2 ex officio members (Director, Department of Institutions, and Chief, Division of Health Services, State Department of Health). Authority for the Committee is statutory.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The State Department of Public Assistance processes and pays all medical vendor claims for services provided under the program except claims for dental services.
<b>b. Fiscal Agents</b>	State Department of Public Assistance has entered into a fiscal agent contract with the Washington Dental Service. Responsibilities of the fiscal agent include the processing, auditing, and payment of claims for dental services and supplies provided under the State's Dental Care Program.
<b>c. Prepaid Capitation Arrangements</b>	Effective September 1, 1969, the State Department of Public Assistance entered into an agreement with the Group Health Cooperative of Puget Sound whereby the Cooperative undertakes to provide comprehensive medical, surgical, and hospital coverage on a prepaid per capita basis (\$39.75 per month per family unit) for approximately 1,000 families living within the Seattle area. Enrollment in the project, which is voluntary, is primarily limited to families applying (or reapplying) for a continuing grant of AFDC, or a grant for a disabled father and AFDC family. Enrollment is not open to couples, single persons, pregnant women with no other children, or families with other medical insurance. Except for emergency hospitalization, services are provided only through the Cooperative's hospital and clinics.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Washington as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 50.00.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made biennially. Unobligated balance may be carried over within the biennium but reverts to the General Fund at the end of the biennium.
<b>4. Deficit Financing</b>	If additional funds are needed before the next appropriation period, limited relief may be made available from the Governor's Contingency Fund. Authorization for such funds must be obtained from the Office of the Governor, the Legislative Budget Committee, and the Legislative Council. In addition, it may also be necessary to reduce the services available.

## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Welfare

January 1, 1970

WEST VIRGINIA

**A. General Information**

<b>1. Legal Base</b>	Article 5, Chapter 9, West Virginia Code. (Amended by Chapter 49, 1966 Regular Session of the State Legislature to provide statutory base for a program of Medical Assistance under title XIX.)
<b>2. Beginning Dates</b>	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on October 13, 1966.
<b>3. Administrative Responsibility</b>	The State Department of Welfare serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of 27 area offices and 28 satellite offices.
<b>4. Historical Background</b>	<p>Vendor payments for medical care with Federal financial participation began in West Virginia in 1956 with the establishment of the State Medical Services Fund to pay for costs of "necessary medical services for recipients of assistance". Substantially the same services were made available to recipients in all categories under the State law, which defined "medical services" broadly. Certain of these services were subject to limitations and requirements for prior authorization. Nursing home care, which was not covered by the vendor payment program, was made available to all recipients as needed through inclusion of a budgeted amount in the monthly money grant.</p> <p>In 1960, on the basis of newly enacted legislation, a Federal-State program of Medical Assistance for the Aged (MAA) was instituted providing medical care (including nursing home care) for persons age 65 or older who were not recipients of public assistance but who met certain criteria of financial and medical need. After November 1963, the MAA program was, with a few exceptions, limited to care and treatment of acute and life-endangering conditions, and to relief of pain.</p>
<b>5. Scope of Coverage</b>	Program provides coverage for categorically needy persons only. (See Item C.3.)
<b>6. Differences in Scope of Services Provided</b>	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exception:</p> <p>Services for persons in institutions for tuberculosis and mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.b. and c., and B.4.b. and c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services covered as benefits under Medicare are made available only to individuals covered by the State's buy-in agreement. (Item B.18.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>	
<b>a. In General Hospitals</b>	Provided. Limited to 60 days in a fiscal year. No requirements for prior authorization, except for elective and rehabilitative procedures which require prior authorization of State Medical Director. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Welfare.
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older who are patients in State hospitals. Up to a maximum of 90 days per admission. No requirements for prior authorization. Reimbursement at per diem rate based on reasonable cost. Claims processed and paid by State Department of Welfare.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older who are patients in State hospitals. Up to a maximum of 90 days per admission. No requirements for prior authorization. Reimbursement at per diem rate based on reasonable cost. Claims processed and paid by State Department of Welfare.



**B. Medical and Remedial Care and Services (Continued)**

<b>2. Outpatient Hospital Services</b>	Provided. No limitations. Prior authorization by State Medical Director required for therapeutic X-ray for conditions other than diagnosed cancer, for physical therapy, and for inhalation therapy. Reimbursement on basis of fee schedule of Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.
<b>3. Other Laboratory and X-ray Services</b>	Provided. No limitations. Prior authorization by State Medical Director required for therapeutic X-ray for conditions other than diagnosed cancer. Reimbursement on basis of fee schedule of Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.
<b>4. Skilled Nursing Home Services</b>	
<b>a. General</b>	Provided. For persons of all ages. Limited to 100 days per benefit period (title XVIII definition). No requirements for prior authorization. Reimbursement on basis of reasonable cost (according to title XVIII principles of reimbursement). Claims processed and paid by State Department of Welfare.
<b>b. In Institutions for Tuberculosis</b>	Provided. Limited to persons age 65 or older who are patients in State hospitals. Up to a maximum of 90 days per admission. No requirements for prior authorization. Reimbursement at per diem rate based on reasonable cost. Claims processed and paid by State Department of Welfare.
<b>c. In Institutions for Mental Diseases</b>	Provided. Limited to persons age 65 or older who are patients in State hospitals. Up to a maximum of 90 days per admission. No requirements for prior authorization. Reimbursement at per diem rate based on reasonable cost. Claims processed and paid by State Department of Welfare.
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
<b>6. Physicians' Services (M.D. and D.O.)</b>	Provided. No limitations. After first visit, prior authorization by State Department required for elective and remedial services. Reimbursement on basis of usual and customary charges up to fee guide maximum allowance. Claims processed and paid by State Department of Welfare.
<b>7. Services of Licensed Practitioners</b>	
<b>a. Podiatrists</b>	Provided. No limitations. After first visit, prior authorization by State office required for elective and remedial services. Reimbursement on basis of fee structure based on Blue Shield allowances. Claims processed and paid by State Department of Welfare.
<b>b. Optometrists</b>	Provided. No limitations. Prior authorization by Visually Handicapped Program of the State Office for eyeglasses, visual training-orthoptics, contact lenses, and artificial eyes. Reimbursement on basis of Department's published visual care fee schedules. Claims processed and paid by State Department of Welfare.
<b>c. Chiropractors</b>	Provided. No limitations. After first visit, prior authorization by State office required for elective and remedial services. Reimbursement on basis of usual and customary charges up to fee guide maximum allowance. Claims processed and paid by State Department of Welfare.
<b>d. Other</b>	Not provided.

**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. As furnished by home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charges (as paid by Social Security Administration for title XVIII benefits). Claims processed and paid by State Department of Welfare.</p> <p>(b) Services of home health aide. As furnished by home health agency. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable charges (as paid by Social Security Administration for title XVIII benefits). Claims processed and paid by State Department of Welfare.</p> <p>(c) Medical supplies, equipment, and appliances. Provided as prescribed, ordered, or recommended by physician. No limitations. Prior authorization by county office required for medical supplies costing under \$10; by State Medical Director for supplies costing \$10 or more, for appliances, and for purchase or rental of durable equipment. Syringes, needles, and other diabetic supplies do not require prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by State Department of Welfare.</p>								
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Provided. Limited to services provided to hospital inpatients. Prior authorization of State Medical Director required. Reimbursement on basis of customary charges which are reasonable. Claims processed and paid by State Department of Welfare.</p>								
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on visit basis at negotiated rates related to cost. Claims processed and paid by State Department of Welfare.</p>								
<b>11. Dental Services</b>	<p>Provided. Services for adults limited to acute and emergency care, with remedial care for selected cases. Comprehensive care provided for children, including orthodontic services. Prior approval by State Dental Consultant on all treatment plans for services other than emergency and palliative care. Reimbursement on basis of published fee schedule (based on Dental Service Corporation fees, 1964). Claims processed and paid by State Department of Welfare.</p>								
<b>12. Physical Therapy and Related Services</b>	<table border="1"> <tr> <td data-bbox="137 1255 352 1283"><b>a. Physical Therapy</b></td><td data-bbox="456 1255 1477 1402"> <p>Provided. As a "planned service" based on social and medical evaluation of individual situation. Limited to cases prescribed by physician, provided by registered physical therapists, given prior approval by State Medical Director, and formally authorized by county office. Reimbursement on basis of fee schedule of Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.</p> </td></tr> <tr> <td data-bbox="137 1434 312 1491"><b>b. Occupational Therapy</b></td><td data-bbox="456 1434 608 1461"> <p>Not provided.</p> </td></tr> <tr> <td data-bbox="137 1522 341 1549"><b>c. Speech Therapy</b></td><td data-bbox="456 1522 1489 1669"> <p>Provided. As a "planned service", based on social and medical evaluation of individual situation. Limited to cases recommended by physician, evaluated by a Speech and Hearing Center, approved by State Medical Director, and formally authorized by county office. Reimbursement on basis of fee schedule of State office Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.</p> </td></tr> <tr> <td data-bbox="137 1701 280 1728"><b>d. Audiology</b></td><td data-bbox="456 1701 1489 1848"> <p>Provided. As a "planned service", based on social and medical evaluation of individual situation. Limited to cases recommended by physician, evaluated by a Speech and Hearing Center, approved by State Medical Director, and formally authorized by county office. Reimbursement on basis of fee schedule of State office Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.</p> </td></tr> </table>	<b>a. Physical Therapy</b>	<p>Provided. As a "planned service" based on social and medical evaluation of individual situation. Limited to cases prescribed by physician, provided by registered physical therapists, given prior approval by State Medical Director, and formally authorized by county office. Reimbursement on basis of fee schedule of Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.</p>	<b>b. Occupational Therapy</b>	<p>Not provided.</p>	<b>c. Speech Therapy</b>	<p>Provided. As a "planned service", based on social and medical evaluation of individual situation. Limited to cases recommended by physician, evaluated by a Speech and Hearing Center, approved by State Medical Director, and formally authorized by county office. Reimbursement on basis of fee schedule of State office Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.</p>	<b>d. Audiology</b>	<p>Provided. As a "planned service", based on social and medical evaluation of individual situation. Limited to cases recommended by physician, evaluated by a Speech and Hearing Center, approved by State Medical Director, and formally authorized by county office. Reimbursement on basis of fee schedule of State office Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.</p>
<b>a. Physical Therapy</b>	<p>Provided. As a "planned service" based on social and medical evaluation of individual situation. Limited to cases prescribed by physician, provided by registered physical therapists, given prior approval by State Medical Director, and formally authorized by county office. Reimbursement on basis of fee schedule of Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.</p>								
<b>b. Occupational Therapy</b>	<p>Not provided.</p>								
<b>c. Speech Therapy</b>	<p>Provided. As a "planned service", based on social and medical evaluation of individual situation. Limited to cases recommended by physician, evaluated by a Speech and Hearing Center, approved by State Medical Director, and formally authorized by county office. Reimbursement on basis of fee schedule of State office Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.</p>								
<b>d. Audiology</b>	<p>Provided. As a "planned service", based on social and medical evaluation of individual situation. Limited to cases recommended by physician, evaluated by a Speech and Hearing Center, approved by State Medical Director, and formally authorized by county office. Reimbursement on basis of fee schedule of State office Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.</p>								



**B. Medical and Remedial Care and Services (Continued)**

<b>13. Prescribed Drugs</b>	Provided. All legend drugs, with exception of a few non-essential categories; plus certain categories of non-legend drugs used in treatment of chronic conditions. Prior authorization of Psychiatrist Consultant required for psychotherapeutic drugs; prior authorization of Medical Director for other drug therapy not covered in program regulations. Reimbursement for legend items on basis of wholesale acquisition cost (Blue Book or Red Book listings) plus a graduated percentage mark-up (decreasing as cost of drug increases) but not to exceed published Drug Cost Standards; for non-legend items on basis of customary charges that are reasonable. Minimum charge, \$1.50; maximum, vendor's charge to general public. Claims processed and paid by State Department of Welfare.
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. No limitations. Prior authorization by Visual Handicapped Program, State Office, Division of Medical Care, required for eyeglasses and contact lenses. Reimbursement on basis of State Department's published Visual Care Fee Schedule. Claims processed and paid by State Department of Welfare.
<b>b. Hearing Aids</b>	Provided. As a "planned service", based on social and medical evaluation of individual situation. Limited to cases recommended by physician, evaluated by a Speech and Hearing Center, approved by State Medical Director, and formally authorized by county office. Reimbursement on basis of fee schedule of State office Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.
<b>c. Dentures</b>	Provided. Children are covered and adults meeting criteria for remedial services. All treatment plans are approved and authorized by State Dental Consultant. Reimbursement on basis of published fee schedule (based on Dental Service Corporation fees, 1964). Claims processed and paid by State Department of Welfare.
<b>d. Other Prosthetic Devices</b>	Provided. Prosthetic devices prescribed to replace a missing portion of the body, or to prevent or correct a physical deformity or malfunction, including artificial limbs and braces. Must be prescribed by physician specializing in orthopedics on other appropriate speciality. Prior approval by State Medical Director and formal authorization by county office required. Reimbursement on basis of fee schedule of State office Division of Vocational Rehabilitation. Claims processed and paid by State Department of Welfare.
<b>15. Family Planning Services</b>	Provided. Under direction of physician. Including drugs, supplies, and devices. No limitations. No requirements for prior authorization. Reimbursement to physicians on basis of usual and customary charges up to fee guide maximum allowances; to pharmacies on basis of acquisition cost plus a graduated percentage mark-up. Claims processed and paid by State Department of Welfare.
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. Limited to persons age 65 or older. No requirements for prior authorization. Reimbursement on basis of Medicare deductible. Claims processed and paid by State Department of Welfare.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. Limitations related to type of service. Reimbursement according to type of provider services. Claims processed and paid by State Department of Welfare.

**B. Medical and Remedial Care and Services (Continued)**

<b>21. Transportation</b>  <b>a. Ambulance</b>          <b>b. Other</b>	<p>Provided. When medically indicated and when other means of transportation would jeopardize patient. Physician's certification required except for emergency care and treatment. Prior authorization from county office for ambulance to nursing home, and from nursing home to own home. Payments only to ambulance companies certified for participation in Medicare. Reimbursement on basis of \$10 for first 5 miles, plus 25¢ for each additional mile traveled. Claims processed and paid by State Department of Welfare.</p> <p>Provided. By common carrier or other appropriate means; including cost of outside meals and lodgings enroute and during treatment period away from home, and cost of attendant. Provided according to medical need; no limitations. Prior approval from State Medical Director required for transportation to other than nearest medical facility, e.g., to medical teaching center or rehabilitation center. Reimbursement of common carriers on basis of rate approved by Public Service Commission or Interstate Commerce Commission; of private vehicle at rate of 8¢ per mile or by purchase of gasoline and oil, whichever is less. Claims processed and paid by State Department of Welfare.</p>
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**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is entitled to assistance as early as the date of application; provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>  <b>a. Under Age 21</b>          <b>b. Age 21 to 64</b>          <b>c. Age 65 or older</b>	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p> <p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan).  <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent; or unemployment of father.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Child in foster home or private institution under the supervision of the Division of Child Welfare. (Non-AFDC foster care)</p> <p>(4) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(5) Person who is blind (State definition).</p> <p>(6) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.  (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p>(1) Individual who has attained age 65.</p>



**C. Eligibility for Medical Assistance (Continued)**

3. Coverage of the Categorically Needy	Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:
a. FFP Claimed in Medical and Administrative Costs	<p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons in an institution for tuberculosis or mental disease or in an extended care facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for OAA if they left the facility.</p> <p>(5) All children under age 21 in foster homes or private institutions under the supervision of the Division of Child Welfare.</p> <p>(6) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD. (Categorically needy only)</p>
b. FFP Claimed in Administrative Costs Only	<p style="text-align: center;"><i>Optional</i></p> <p>(1) Individuals receiving General Assistance.</p> <p>(2) Children under age 21 receiving services through the Division of Child Welfare, other than foster care.</p>
4. Coverage of the Medically Needy	Not included.
5. Financial Criteria	The following criteria are used in establishing financial eligibility for medical assistance:
a. For Categorically Needy Persons	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
b. For Medically Needy Persons	Not applicable.
6. Financial Responsibility of Relatives	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21.
7. Identification to Vendors of Persons Eligible	A Medical Identification Card is issued monthly by the State Department of Welfare through its Data Processing System to each case certified as eligible for medical assistance. Face of card shows certificate number, case name and period of eligibility as well as initials and birth date of each eligible family member included in the case.

**D. Administration and Management**

1. Medical Assistance Unit	The Division of Medical Care (medical assistance unit) is located organizationally under the Assistant Commissioner for Programs and Services, who is responsible directly to the Commissioner of Welfare. Full-time professional staff of the Division consists of the Director, a pharmaceutical consultant (R.Ph.), a nursing consultant (RN), social work consultant (ACSW), psychologist (M.A.). This staff is supplemented by the part-time services of a medical director (M.D.), a psychiatric consultant (M.D.), and a dental consultant (D.D.S.).
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**D. Administration and Management (Continued)**

<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the activities of 3 field representatives assigned to specific geographic areas.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Services Advisory Council. It is composed of six members appointed by the Commissioner of Welfare. The State Director of Public Health is an ex officio member. Authority for the Council is statutory.
<b>4. Buy-In Agreement</b>	State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	All phases of the activities involved in the processing, review, and payment of vendor claims are accomplished by the State Department of Welfare.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for West Virginia as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 75.73.
<b>2. State/Local Participation</b>	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
<b>3. Source of State Funds</b>	State's share of program costs is derived from appropriations made annually. Unobligated balance may be carried over to the next fiscal year.
<b>4. Deficit Financing</b>	Deficit spending is not permitted under State law. If additional funds are needed before the next appropriation period, the program must be curtailed.



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health and  
Social Services

January 1, 1970

WISCONSIN

### A. General Information

1. Legal Base	Sections 49.45, 49.46, and 49.47 Wisconsin Statutes.
2. Beginning Dates	Program went into operation on July 1, 1966. Original plan approved by the Federal agency on October 11, 1966.
3. Administrative Responsibility	The Department of Health and Social Services serves as the single State agency with responsibility for administering the program on a Statewide basis through a system of local offices.
4. Historical Background	<p>Vendor payments for costs of medical care with Federal financial participation began July 1, 1957, for recipients of assistance under OAA, AB, APTD, and AFDC. The broad scope of services which was authorized under the State's statute was available to recipients in all four categories. In July 1964 the State added a Federal-State program of Medical Assistance for the Aged (MAA), designed for persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need.</p> <p>The State law specified that the MAA recipient must have expended or obligated 5% of his annual allowable income for health care benefits included in the scope of the program (or 5% of actual income if his income was less than the maximum permitted for MAA eligibility). In administering the program, the State was required by statute to negotiate a contract "with the lowest bidding qualified non-profit organization or insurance company to act as fiscal agency and to administer the payment of health care benefits." The Continental Casualty Company won the contract, thus making Wisconsin the only State at that time using a contract with a commercial insurance company as fiscal agent. The enabling legislation also prescribed the duties of the local agencies, under the supervision of the State agency, to accept and process applications and to certify eligibility of applicants to the contractor.</p> <p>The kinds of services provided under MAA were similar to but more limited than those provided to recipients of public assistance. Inpatient hospital care was limited to 45 days per illness, nursing home care was defined as post-hospital care in a skilled nursing home within the overall 45-day period, and the services of both physicians and dentists were linked to this period of hospital and nursing home care and to provision of services in these institutions. In addition the program provided for hospital outpatient services, prescribed drugs, diagnostic X-ray and laboratory services provided by a private laboratory operated by a physician, and visiting nurse services.</p>
5. Scope of Coverage	Program provides coverage for both categorically needy and medically needy persons. (See Items C.3. and C.4.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to both the categorically needy and the medically needy is equal in amount, duration, and scope for all individuals with the following exceptions:</p> <p>Services for persons in institutions for mental diseases are provided only for patients who are 65 years of age or older. (Items B.1.c. and B.4.c.)</p> <p>Early screening and diagnosis of physical or mental defects, and treatment of conditions found, are provided only for persons under 21 years of age. (Item B.5.)</p> <p>Certain services provided for categorically needy persons are not made available to medically needy persons. (Items B.7.a., b., and d.; B.9.; B.12.c. and d.; B.14.a., b., and d.; B.16; B.17; B.20; B.21a. and b.)</p> <p>Certain services provided for categorically needy persons are made available on a more limited basis to medically needy persons. (Items B.1.a. and c.; B.4.a. and c.; B.8.(a) and (b); B.13.; B.15.; B.18.)</p> <p>[NOTE: Under Item B.4.a., services for medically needy persons in skilled nursing homes are provided only for individuals age 21 or older, and for a limited number of days.]</p>





**B. Medical and Remedial Care and Services (Continued)**

<b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to patients age 65 or older in State mental hospitals and in county mental hospitals certified for the provision of skilled nursing care. Unlimited services for categorically needy persons. For medically needy persons, provided only for patients admitted to the institution direct from hospital, and limited to a combined maximum of 45 days "per illness" of inpatient care received in a general hospital, skilled nursing home, or institution for mental diseases. (One "illness" defined as (1) all illnesses existing simultaneously which are due to the same or related causes, or (2) successive periods of illness less than 6 months apart, which are due to the same or related causes.) No requirements for prior authorization. Reimbursement on basis of reasonable cost (current per-capita cost). Claims processed and paid by fiscal agent (Associated Hospital Service, Inc.).</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>As provided in regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. No limitations. No requirements for prior authorization under usual circumstances. Reimbursement on basis of usual and customary charges not in excess of schedule of maximum allowances as determined by the State agency, or reasonable charges as determined by Medicare, whichever is less. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).</p>
<b>7. Services of Licensed Practitioners</b>  <b>a. Podiatrists</b>   <b>b. Optometrists</b>   <b>c. Chiropractors</b>  <b>d. Other</b>	<p>Provided. For categorically needy persons only. Routine foot care excluded. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges, not in excess of schedule of maximum allowances as determined by the State agency, or reasonable charges as determined by Medicare, whichever is less. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Association of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).</p> <p>Provided. For categorically needy persons only. No requirements for prior authorization. Reimbursement on basis of usual and customary charges, not in excess of schedule of maximum allowances. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).</p> <p>Not provided.</p> <p><i>Psychologist services:</i> Provided. For categorically needy persons only. Testing, consultation and treatment services provided when prescribed and under supervision of a physician as part of a medical-psychiatric treatment program. Reimbursement on basis of usual, customary charges, not in excess of schedule of maximum allowances as determined by the State agency. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).</p>

**B. Medical and Remedial Care and Services (Continued)**

<b>8. Home Health Care Services</b>	<p>The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:</p> <p>(a) Intermittent or part-time nursing service. Provided. As prescribed or ordered by attending physician. For categorically needy persons, as furnished by a qualified home health agency or by an independent RN or LPN. For medically needy persons, limited to services furnished by a Visiting Nurse Association or county home nursing service, with payment to RN or LPN only when services of such an association or county service are unavailable in the area. No limitation on number of visits. No requirements for prior authorization. Reimbursement on basis of usual and customary charges; payment to home health agency not to exceed schedule of maximum allowances as determined by the State agency, or reasonable cost as determined by Medicare; payment to other vendors not to exceed schedule of maximum allowances. Claims processed and paid by fiscal agent (for home health agencies, Associated Hospital Service, Inc.; for other vendors, Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).</p> <p>(b) Services of home health aide. Provided. For categorically needy persons. As furnished by home health agency, on prescription or order of attending physician. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges, not to exceed schedule of maximum allowances as determined by the State agency, or reasonable cost as determined by Medicare, whichever is less. Claims processed and paid by fiscal agent (Associated Hospital Service, Inc.).</p> <p>(c) Medical supplies, equipment, and appliances. Provided. All items exceeding \$25 in cost must have prior authorization by the State agency. Reimbursement on basis of usual and customary charges not in excess of schedule of maximum allowances. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).</p>
<b>9. Private Duty Nursing Services (RN or LPN)</b>	<p>Provided. For categorically needy persons only. Full-time private duty nursing in hospital and skilled nursing home, when ordered by attending physician. No other requirement for prior authorization. Reimbursement on basis of usual and customary charges, not in excess of schedule of maximum allowances. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).</p>
<b>10. Clinic Services (Other than Hospital)</b>	<p>Provided. Limited to community mental health clinics. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges, as approved by Medical Services Section of State agency, not in excess of reasonable cost. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).</p>
<b>11. Dental Services</b>	<p>Provided. Orthodontia limited to cases which present a handicapping malocclusion or handicapping dental facial deformity. No other limitations. Prior authorization by State agency required for most of the more difficult, time-consuming, and/or costly procedures and materials. Reimbursement on basis of usual and customary charges not in excess of schedule of maximum allowances. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).</p>
<b>12. Physical Therapy and Related Services</b>	<p><b>a. Physical Therapy</b></p> <p>Provided. As prescribed or ordered by physician. No limitations. Prior authorization by State agency required for extension of therapy provided to patient in nursing home beyond a 60-day treatment period. Reimbursement on basis of usual, customary, and reasonable charges not in excess of maximums established by State agency. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Association of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>b. Occupational Therapy</b>	Provided. As prescribed or ordered by physician. No limitations. Prior authorization by State agency required for extension of therapy provided to patient in nursing home beyond a 60-day treatment period. Reimbursement on basis of usual, customary, and reasonable charges not in excess of maximums established by State agency. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Association of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).
<b>c. Speech Therapy</b>	Provided. For categorically needy persons only. No other limitations. Prior authorization by State agency required for extension of therapy provided to a patient in nursing home beyond a 60-day treatment period. Reimbursement on basis of usual, customary, and reasonable charges not in excess of maximums established by State agency. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Association of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).
<b>d. Audiology</b>	Provided. For categorically needy persons only. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges not in excess of maximums established by State agency. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Association of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the State Medical Society of Milwaukee County).
<b>13. Prescribed Drugs</b>	Provided. Legend and non-legend drugs, as prescribed by physician or dentist. For medically needy persons, non-legend drugs limited to insulin. Limit of 34-day supply on one prescription. No requirements for prior authorization. Reimbursement for legend drugs on basis of usual and customary charges not in excess of cost (Blue Book or Red Book price) plus dispensing fee not to exceed \$2.00; of non-legend drugs on basis of usual charge to general public. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).
<b>14. Prosthetic Devices</b>	
<b>a. Eyeglasses</b>	Provided. For categorically needy persons only. No other limitations. No requirements for prior authorization except for contact lenses. Reimbursement on basis of usual and customary charges not in excess of schedule of maximum allowances. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).
<b>b. Hearing Aids</b>	Provided. For categorically needy persons only. Hearing aids, accessories (ear molds, batteries, etc.), repairs, and replacements. Prior written authorization by State office required for purchase of hearing aid for persons age 21 or older; request must be accompanied by medical report and hearing evaluation from an approved speech and hearing center. (Medical report and hearing evaluation not required for persons under age 21; county agency forwards request for hearing aid to Bureau of Handicapped Children which provides complete service including purchase of hearing aids.) Payment for hearing aids, accessories, and repairs authorized only when purchased from dealer on approved list, if cost exceeds \$25. Reimbursement on basis of usual, customary, and reasonable charges, subject to approval of State office. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).
<b>c. Dentures</b>	Provided. For all recipients except those who have been edentulous without replacement for a period of 3 years. No other limitations. Prior authorization by State agency required. Reimbursement on basis of usual, customary, and reasonable charges, not in excess of maximums established by Medical Section of State agency. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).
<b>d. Other Prosthetic Devices</b>	Provided. For categorically needy persons only. Any prosthetic device prescribed by a physician. No other limitations. Prior authorization by State agency required. Reimbursement on basis of usual charges, not in excess of maximums established by Medical Section of State agency. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).

**B. Medical and Remedial Care and Services (Continued)**

<b>15. Family Planning Services</b>	Provided. Professional services, plus drugs, supplies, and devices. For medically needy persons, limited to professional services and drugs. No other limitations. No requirements for prior authorization. Reimbursement of professional services on basis of usual, customary, and reasonable charges, not in excess of maximums established by Medical Section of State agency; of drugs and devices, on basis of usual charge to general public. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).
<b>16. Services of Christian Science Nurses</b>	Provided. For categorically needy persons only. Private duty service when furnished by a Christian Science visiting nurse service to an individual in his own home or in a Christian Science Sanatorium. No limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges, not in excess of maximums established by Medical Section of State agency. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).
<b>17. Care and Services in Christian Science Sanatoria</b>	Provided. For categorically needy persons only. No other limitations. No requirements for prior authorization. Reimbursement on basis of usual, customary, and reasonable charges, subject to approval by Medical Section of State agency, with utilization of profiles of services provided, cost analysis, etc. Claims processed and paid by fiscal agent (Associated Hospital Service, Inc.).
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Provided. For categorically needy persons, for as long as medically necessary. For medically needy, limited to maximum of 45-days in a 6-month period. Reimbursement on basis of reasonable cost (according to Medicare principles of reimbursement). Claims processed and paid by fiscal agent (Associated Hospital Service, Inc.).
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Provided. For categorically needy persons only. Covers community sponsored disease detection programs. Reimbursement on basis of usual, customary, and reasonable charges, not in excess of schedule of maximum allowances. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Society of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).
<b>21. Transportation</b>	
<b>a. Ambulance</b>	Provided. For categorically needy persons only. In emergencies and when patient's condition precludes safe use of other means of transportation. No limitations. No requirements for prior authorization. Reimbursement on basis of usual and customary charges not in excess of schedule of maximum allowances. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Association of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).
<b>b. Other</b>	Provided. For categorically needy persons only. By authorized emergency vehicles. Including lodgings and meals enroute, and the services of an attendant when medically indicated. Reimbursement on basis of usual, customary, and reasonable charges not in excess of maximums established by State agency. Claims processed and paid by fiscal agent (Wisconsin Physicians Service of the State Medical Association of Wisconsin <i>or</i> Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County).

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as the first day of the second month preceding the month of application, provided all conditions of eligibility were met in the month in which services were rendered.
<b>2. Conditions of Eligibility (By Age Groups)</b>	The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:
<b>a. Under Age 21</b>	(1) All individuals under age 21.



**C. Eligibility for Medical Assistance (Continued)**

b. Age 21 to 64	<p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age and school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p>
c. Age 65 or older	<p>(1) Individual who has attained age 65.</p>
3. Coverage of the Categorically Needy	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>a. FFP Claimed in Medical and Administrative Costs</p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons eligible for but not receiving OAA, AB, APTD, or AFDC.</p> <p>(5) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(6) All individuals under age 21.</p> <p>(7) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p style="text-align: center;"><i>Optional</i></p> <p>b. FFP Claimed in Administrative Costs Only</p> <p>(1) Persons (other than the essential spouse) living with and providing a service essential to the well-being of a recipient of OAA, AB, or APTD which otherwise would have to be purchased from another individual, provided the needs of such person are taken into account in determining the amount of assistance furnished. (Categorically needy only.)</p> <p>(2) Persons meeting all criteria for eligibility under the program except that they are in non-patient status in county homes or county general hospitals which <i>have been approved as public medical institutions</i>. (Claim for Federal financial participation in administrative costs limited to those associated with the furnishing of non-institutional items of medical assistance available under the State's program.)</p> <p>(3) Persons meeting all criteria for eligibility under the program except that they are in a county home or county general hospital which has <i>not been approved as a public medical institution</i>. (Claim for Federal financial participation in administrative costs limited to those associated with the furnishing of non-institutional items of medical assistance available under the State's program.)</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>4. Coverage of the Medically Needy</b>	Coverage is extended to "medically needy" individuals, i.e., persons meeting the conditions of eligibility of one of the groups described in Items C.3.a. and b. (except 3.a.(7) and 3.b.(1) ) above, whose income and resources exceed the levels established under the State's plans for OAA, AB, APTD and AFDC but are insufficient to meet the costs of needed medical care. Full medical assistance under the plan is provided to such medically needy persons whose income and resources are at or below the levels protected for basic maintenance needs (see Item C.5.b.); payment for medical assistance provided to persons with income and resources above such levels is reduced by the dollar amount of the excess in accordance with the regulations.
<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	<p data-bbox="461 594 580 619"><i>(1) Income</i></p> <p data-bbox="501 653 1477 737">Annual income which may be retained for basic maintenance needs: \$1600 for one person, \$2500 for family of 2, \$2800 for 3, \$3100 for 4, and \$300 for each additional legal dependent.</p> <p data-bbox="501 768 1469 821">Person in chronic (long-term) care in a medical facility may retain \$9 a month for personal expenses. Additional income may be applied to maintenance needs of dependents.</p> <p data-bbox="501 852 1305 877">Income in excess of these amounts must be applied to cost of medical care.</p> <p data-bbox="461 915 608 940"><i>(2) Resources</i></p> <p data-bbox="501 972 1477 1024">Home and land used in connection with it, or a mobile home used as a place of abode, may be retained up to an equity of \$7500.</p> <p data-bbox="501 1056 1501 1171">Household furnishings and personal possessions, including an automobile, may be retained up to a value of \$2000. Value of all other resources and property, including income-producing property, may not exceed \$1500 for one person, \$2500 for a family of 2, plus \$300 for each additional dependent.</p> <p data-bbox="501 1203 1477 1262">Resources in excess of these amounts disqualify applicant from receiving medical assistance under the program.</p>
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children under age 21.
<b>7. Identification to Vendors of Persons Eligible</b>	A Certification Card for identification purposes is issued by the county agency to eligible individuals or family groups for a period not in excess of one year. The card shows names of all eligible family members, sex, date of birth, case identification number, certified period of eligibility, address of family, signature of head of family, name and address of county welfare department and signature of county welfare director. Applicants having excess income are not certified until the point in time at which the excess is expended. The Certification Card for the medically needy is the same as for the categorically needy except for color of the card and designation of a different health care benefit level for the medically needy.



**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	<p>The Director of Medical Services, a physician, is responsible to the Administrator of the Division of Family Services in the Department of Health and Social Services. The other full-time professional staff consists of: an Assistant to the Medical Director (MSW) with an Administrative Officer, a Staff Development Consultant, and a Medical Procedures Consultant (all from the field of social work), and a Dental Consultant. The staff is further augmented by a part-time Orthodontic Consultant, a part-time Pharmaceutical Consultant, a part-time Medical Social Worker, and 2 consultants (1 full-time, 1 part-time) for disability and blindness determinations related to Medical Assistance.</p> <p>The staff responsible for the segment of the program relating to services in institutions for mental diseases is headed by a Psychiatric Consultant (responsible to the Director of Medical Services). In addition there are 3 Psychiatric Social Workers, each of whom devotes 1/3 time to the program.</p> <p>An Activity Program Consultant provides services to county homes approved as public medical institutions which largely serve Medical Assistance recipients. Other full-time staff are an Auditor Supervisor and 3 field auditors involved in establishing rates for skilled nursing homes.</p> <p>Quarterly reviews in institutions for mental diseases and Independent Medical Review in skilled nursing homes are the responsibility of a Supervisor of Medical Assistance Social Workers, a Nursing Services Consultant Supervisor (R.N.), 2 Social Work Field Supervisors, 18 Medical Assistance Social Workers, and 6 Nursing Services Consultants (R.N.).</p>						
<b>2. Supervision of Statewide Operations</b>	<p>Supervision of the medical aspects of Statewide operations is accomplished through the consultative and supervisory staff listed in Item D.1. above in the medical assistance unit. In addition, in one large metropolitan area (Milwaukee County Department of Public Welfare) there is a Medical Division staffed by 40 full-time social workers.</p> <p>The supervision of eligibility and other public assistance aspects of the program, Statewide, is accomplished through the regular supervisory and consultative staff of the Division of Family Services in the State office and similar field staff assigned to 5 regional offices.</p>						
<b>3. Advisory Council</b>	<p>The State advisory body for title XIX is known as the Medical Assistance Advisory Committee. It is composed of 15 members appointed by the State agency. There are 5 ex officio members (4 representatives of the Medical Services Section and a Research Analyst of the Division of Family Services). Authority for the Committee is statutory.</p>						
<b>4. Buy-In Agreement</b>	<p>State has entered into a buy-in agreement with the Social Security Administration for payment of Supplementary Medical Insurance premiums on behalf of all money payment recipients age 65 or older who are eligible for benefits under title XVIII of the Social Security Act.</p>						
<b>5. Claims Payment Process</b>	<table border="1"> <tr> <td data-bbox="76 1333 454 1480"> <b>a. State and Local Agencies</b> </td><td data-bbox="454 1333 1540 1480"> None. </td></tr> <tr> <td data-bbox="76 1480 454 1837"> <b>b. Fiscal Agents</b> </td><td data-bbox="454 1480 1540 1837"> <p>The State Department of Health and Social Services has entered into a fiscal agent contract with Associated Hospital Service, Inc. (Blue Cross) and a joint fiscal agent contract with Wisconsin Physicians Service of the State Medical Society of Wisconsin (Blue Shield) and Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County. Under the terms of these contracts, all vendor claims from institutions (hospitals, skilled nursing homes, Christian Science Sanatoria, and home health agencies) are processed and paid by Associated Hospital Service, Inc. Claims from all other vendors are processed and paid by Wisconsin Physicians Service with the exception of those submitted by providers in Milwaukee County and by out-of-State vendors who have provided non-institutional services to residents of Milwaukee County while they were temporarily absent from the State. The latter are handled by Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County.</p> </td></tr> <tr> <td data-bbox="76 1837 454 1938"> <b>c. Prepaid Capitation Arrangements</b> </td><td data-bbox="454 1837 1540 1938"> None. </td></tr> </table>	<b>a. State and Local Agencies</b>	None.	<b>b. Fiscal Agents</b>	<p>The State Department of Health and Social Services has entered into a fiscal agent contract with Associated Hospital Service, Inc. (Blue Cross) and a joint fiscal agent contract with Wisconsin Physicians Service of the State Medical Society of Wisconsin (Blue Shield) and Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County. Under the terms of these contracts, all vendor claims from institutions (hospitals, skilled nursing homes, Christian Science Sanatoria, and home health agencies) are processed and paid by Associated Hospital Service, Inc. Claims from all other vendors are processed and paid by Wisconsin Physicians Service with the exception of those submitted by providers in Milwaukee County and by out-of-State vendors who have provided non-institutional services to residents of Milwaukee County while they were temporarily absent from the State. The latter are handled by Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County.</p>	<b>c. Prepaid Capitation Arrangements</b>	None.
<b>a. State and Local Agencies</b>	None.						
<b>b. Fiscal Agents</b>	<p>The State Department of Health and Social Services has entered into a fiscal agent contract with Associated Hospital Service, Inc. (Blue Cross) and a joint fiscal agent contract with Wisconsin Physicians Service of the State Medical Society of Wisconsin (Blue Shield) and Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County. Under the terms of these contracts, all vendor claims from institutions (hospitals, skilled nursing homes, Christian Science Sanatoria, and home health agencies) are processed and paid by Associated Hospital Service, Inc. Claims from all other vendors are processed and paid by Wisconsin Physicians Service with the exception of those submitted by providers in Milwaukee County and by out-of-State vendors who have provided non-institutional services to residents of Milwaukee County while they were temporarily absent from the State. The latter are handled by Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County.</p>						
<b>c. Prepaid Capitation Arrangements</b>	None.						

**D. Administration and Management (Continued)**

<b>d. Payments to Non-Medical Institutions</b>	None.
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**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Wisconsin as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 55.21.
<b>2. State/Local Participation</b>	<p>State funds are used to pay 100% of State administrative costs, 45% to 80% of county administrative costs, and 45% to 80% of assistance costs for medical services. Local funds are used to pay the remaining 55% to 20% under a variable equalization formula related to the county's ability to pay.</p> <p>The variable percentages for the counties are determined each year, effective January 1, by the percentage relationship between the mill rate for each county and the Statewide mill rate. "Mill rate" is determined by dividing the non-Federal share of the Social Security assistance programs and Medical Assistance by the State full value of all general taxable property in each county.</p>
<b>3. Source of State Funds</b>	State's share of program costs is derived from an appropriation for Medical Assistance made biennially on a "sum-sufficient" basis, that is, an "open-end" State appropriation.
<b>4. Deficit Financing</b>	There is no statutory prohibition against deficit financing but no need for such financing because of the "sum-sufficient" type of appropriation (open-end).



## MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Department of Health and Social Services  
Division of Health and Medical Services

January 1, 1970

WYOMING

### A. General Information

1. Legal Base	Chapter 238, Session Laws of Wyoming, 1967.
2. Beginning Dates	Program went into operation on July 1, 1967. Original plan approved by the Federal agency on September 29, 1967.
3. Administrative Responsibility	<p>The Wyoming Division of Health and Medical Services (within the Department of Health and Social Services) serves as the single State agency with responsibility for administering the program on a Statewide basis.</p> <p>Determination of eligibility for medical assistance is made by the county departments of public welfare which administer the State's Title I plan under the supervision of the Division of Public Assistance and Social Services.</p>
4. Historical Background	<p>The first provisions for payment of the costs of medical care with Federal financial participation as a part of the Federal-State public assistance programs went into effect July 1, 1957, for all four categories under the supervision of the State Department of Public Welfare. The Legislature earlier that year had taken action to redefine the public assistance programs to include vendor payments for medical care but did not provide State funds to meet the costs of such care. County funds derived from a special tax levy (1 mill or less) on real property, which had long supplied the "General Health Welfare" fund in those counties that made such a levy, were used to meet the non-Federal share of the costs of medical care. The services thus provided to recipients of OAA, AB, APTD, and AFDC were limited to inpatient hospital care, physicians' services, and part of the cost of nursing home care. The "board and room component" of nursing home care was provided through the money payment to the recipient. Because of the disparity in the special tax levy among the counties and the lack of an equalization fund from State monies to help the poorer counties, the amount of the services provided varied among the counties.</p> <p>This pattern continued for medical care under the four public assistance categories even after 1963 when State funds were appropriated for the non-Federal share of the cost of the newly enacted program of Medical Assistance for the Aged. This Federal-State program was designed to aid persons age 65 and older who were not recipients of public assistance but who met certain criteria of financial and medical need. Services began July 1963, with inpatient hospital care up to 70 days a year, outpatient hospital care for initial treatment of emergency accident cases or for minor surgery, services of a physician, dental surgery or other procedures which a medical doctor said required hospitalization, and X-ray and laboratory services in a physician's office or the outpatient department of a hospital. By law, the applicant was responsible for the first \$100 per year of costs incurred for medical care provided under the act. In July 1965 this deductible was reduced to \$25 per year.</p> <p>The State agency contracted with Wyoming Hospital Service (Blue Cross) and Wyoming Medical Service (Blue Shield) as fiscal agents respectively for hospitals and physicians to process and pay claims for services provided under the MAA program. The program continued until repealed in 1967 when the newly authorized title XIX program began under the State Department of Public Health. In 1969 a Department of Health and Social Services was established, combining the two earlier departments.</p>
5. Scope of Coverage	Program provides coverage for categorically needy persons only. (See Item C.3.)
6. Differences in Scope of Services Provided	<p>Medical assistance made available to the categorically needy is equal in amount, duration, and scope for all individuals with the following exception:</p> <p>Services in skilled nursing homes are provided only for persons 21 years of age or older. (Item B.4.)</p>

**B. Medical and Remedial Care and Services**

<b>1. Inpatient Hospital Services</b>  <b>a. In General Hospitals</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. No limitations. Prior authorization required for services extending beyond 14 days per spell of illness. Reimbursement on basis of reasonable cost (according to Medicare principles and standards). Claims processed and paid by Division of Health and Medical Services.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>2. Outpatient Hospital Services</b>	<p>Provided. As recommended by a physician. No limitations. No requirements for prior authorization. Reimbursement on basis of reasonable cost. Claims processed and paid by Division of Health and Medical Services.</p>
<b>3. Other Laboratory and X-ray Services</b>	<p>Provided. No limitations. No requirements for prior authorization. Reimbursement on basis of customary charges, not to exceed schedule of maximum allowable charges or reasonable charges as determined by Medicare carrier, whichever is less. Claims processed and paid by Division of Health and Medical Services.</p>
<b>4. Skilled Nursing Home Services</b>  <b>a. General</b>  <b>b. In Institutions for Tuberculosis</b>  <b>c. In Institutions for Mental Diseases</b>	<p>Provided. Limited to persons age 21 or older. No other limitations. Prior authorization by State office required (i.e., Medical and Nursing Care Evaluation is filled out by attending physician, nursing home staff, and caseworker prior to or immediately after patient's admission and submitted through county office to State office where authorization for skilled level of care is jointly determined by physician consultant in Division of Health and Medical Services and staff at the Department level). Reimbursement on basis of a monthly rate of \$310 negotiated with the State Nursing Home Association. Claims processed and paid by Division of Health and Medical Services.</p> <p>Not provided.</p> <p>Not provided.</p>
<b>5. Early and Periodic Screening, Diagnosis, Etc., for Individuals Under Age 21</b>	<p>Not provided.</p>
<b>6. Physicians' Services (M.D. and D.O.)</b>	<p>Provided. Excluding organ transplants and any procedures which would be considered research in nature. 18 "services" per year, with one visit per month to patients in skilled nursing homes regardless of "service" limitation.</p> <p>Definition of a "service":</p> <ol style="list-style-type: none"> <li>1. Surgery (including post-operative care).</li> <li>2. Anesthesiology.</li> <li>3. Hospital care during spell of illness.</li> <li>4. Each visit in office, home, outpatient department, or other.</li> <li>5. Psychiatric interview.</li> <li>6. Physician's consultation.</li> <li>7. Routine Pap smear (1 yearly).</li> <li>8. Well-child examination, first year of life (4 per year; 1 service each).</li> <li>9. Well-child examination, second year of life (1 only).</li> </ol> <p>Prior authorization by State agency required for additional services. Reimbursement on basis of usual and customary charges, not to exceed schedule of maximum allowable charges or reasonable charges as determined by Medicare carrier, whichever is less. Claims processed and paid by Division of Health and Medical Services.</p>



**B. Medical and Remedial Care and Services (Continued)**

<b>7. Services of Licensed Practitioners</b>	
a. Podiatrists	Not provided.
b. Optometrists	Not provided.  [Eye care, including glasses, if they cannot be paid for through other sources, may be provided to children in AFDC families and in AFDC-Foster Care through the State/county non-federally aided "Minimum Medical Program."]
c. Chiropractors	Not provided.
d. Other	Not provided.
<b>8. Home Health Care Services</b>	The following services (in addition to those shown elsewhere in Item B.) are provided to recipient while at home:  (a) [Intermittent or part-time nursing service. Not provided.]  (b) [Services of Home Health Aide. Not provided.]  (c) [Medical supplies, equipment, and appliances. Not provided.]
<b>9. Private Duty Nursing Services (RN or LPN)</b>	Not provided.
<b>10. Clinic Services (Other than Hospital)</b>	Not provided.
<b>11. Dental Services</b>	Not provided.  [Dental care, exclusive of orthodontia, is provided for children in AFDC families and in AFDC-Foster Care through the State/county non-federally aided "Minimum Medical Program". Emergency dental care for adult public assistance recipients may also be provided through this program.]
<b>12. Physical Therapy and Related Services</b>	
a. Physical Therapy	Not provided.
b. Occupational Therapy	Not provided.
c. Speech Therapy	Not provided.
d. Audiology	Not provided.
<b>13. Prescribed Drugs</b>	Not provided.  [Prescription medications are provided for all eligible patients in sheltered nursing care through the State/county non-federally aided "Minimum Medical Program", as well as to other eligible recipients if monthly allocation of funds permits.]

**B. Medical and Remedial Care and Services (Continued)**

<b>14. Prosthetic Devices</b>	
a. Eyeglasses	Not provided.  [Eyeglasses, when unavailable through other sources, are provided to children in AFDC families and in AFDC-Foster Care through the State/county non-federally aided "Minimum Medical Program."]
b. Hearing Aids	Not provided.
c. Dentures	Not provided.
d. Other Prosthetic Devices	Not provided.
<b>15. Family Planning Services</b>	Not provided.  [Payment for physicians' services connected with family planning covered by Item B.6. Payment for required devices and/or prescription medications are provided to public assistance recipients through the State/county non-federally aided "Minimum Medical Program."]
<b>16. Services of Christian Science Nurses</b>	Not provided.
<b>17. Care and Services in Christian Science Sanatoria</b>	Not provided.
<b>18. Emergency Hospital Services (in hospital not qualified under title XVIII or State's title XIX program)</b>	Not provided.
<b>19. Personal Care Services In Patient's Home</b>	Not provided.
<b>20. Other Diagnostic, Screening, Preventive, and Rehabilitative Services</b>	Not provided.  [Physical examinations when required by schools and immunizations recommended by physicians are provided to children in AFDC families and in AFDC-Foster Care through the State/county non-federally aided "Minimum Medical Program."]
<b>21. Transportation</b>	
a. Ambulance	Provided. Limited to ambulance services when necessary to travel to another town. Prior authorization by State office required. Reimbursement on basis of usual, customary, and reasonable charges. Claims processed and paid by Division of Health and Medical Services.
b. Other	Provided. Limited to public transportation when necessary to travel to another town. Prior authorization by State office required. Reimbursement on basis of usual, customary, and reasonable charges. Claims processed and paid by Division of Health and Medical Services.

**C. Eligibility for Medical Assistance**

<b>1. Date of Entitlement</b>	Upon determination of eligibility an individual is retroactively entitled to assistance as early as 60 days prior to date of application, provided all conditions of eligibility were met in the month in which services were rendered.
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**C. Eligibility for Medical Assistance (Continued)**

<p><b>2. Conditions of Eligibility (By Age Groups)</b></p> <p><b>a. Under Age 21</b></p> <p><b>b. Age 21 to 64</b></p> <p><b>c. Age 65 or older</b></p>	<p>The following individuals meet the basic minimum conditions of eligibility for inclusion in groups described in Item C.3.a.:</p> <p>(1) Child deprived of parental support or care, living with a parent or other caretaker relative (as specified in State's AFDC plan). <i>Deprivation Factor:</i> Death, continued absence, or incapacity of a parent.</p> <p>(2) Child in AFDC foster care.</p> <p>(3) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living.</p> <p>(4) Person who is blind (State definition).</p> <p>(5) Person who is permanently and totally disabled (State definition) and age 18 or older.</p> <p>(6) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p>(1) Parent or other caretaker relative (as specified in State's AFDC plan) with whom a child deprived of parental support or care is living. (Parent or relative not eligible unless child meets State's AFDC plan requirements regarding age or school attendance.)</p> <p>(2) Person who is blind (State definition).</p> <p>(3) Person who is permanently and totally disabled (State definition).</p> <p>(4) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p>(1) Individual who has attained age 65.</p>
<p><b>3. Coverage of the Categorically Needy</b></p> <p><b>a. FFP Claimed in Medical and Administrative Costs</b></p> <p><b>b. FFP Claimed in Administrative Costs Only</b></p>	<p>Medical assistance is provided to the following groups of persons with State claim for Federal Financial Participation (FFP) in medical and/or administrative costs:</p> <p style="text-align: center;"><i>Mandatory</i></p> <p>(1) Recipients of OAA, AB, APTD, and AFDC.</p> <p>(2) Persons who would be eligible for OAA, AB, APTD, or AFDC except for an eligibility condition or requirement that is prohibited in a program under title XIX.</p> <p>(3) Individuals under 21 who would be eligible for aid or assistance as dependent children under the State's approved plan for AFDC except for an age or school attendance requirement of the plan.</p> <p style="text-align: center;"><i>Optional</i></p> <p>(4) Persons in a medical facility who are not recipients of financial assistance under the State's OAA, AB, APTD, or AFDC programs but who would be eligible for such assistance if they left the facility.</p> <p>(5) Essential spouse [title XIX definition] of a recipient of OAA, AB, or APTD.</p> <p style="text-align: center;"><i>Optional</i></p> <p>None.</p>
<p><b>4. Coverage of the Medically Needy</b></p>	<p>Not included.</p>

**C. Eligibility for Medical Assistance (Continued)**

<b>5. Financial Criteria</b>	The following criteria are used in establishing financial eligibility for medical assistance:
<b>a. For Categorically Needy Persons</b>	Available income and resources must be at a level which would render the individual eligible for assistance under the public assistance program to which he is characteristically related.
<b>b. For Medically Needy Persons</b>	Not applicable.
<b>6. Financial Responsibility of Relatives</b>	The financial responsibility of relatives for applicants and recipients of medical assistance is limited to the responsibility of spouse for spouse and of parents for children who are under age 21.
<b>7. Identification to Vendors of Persons Eligible</b>	A medical identification card is issued on a one-time basis by the Division of Health and Medical Services to each person or family certified as eligible for medical assistance. The card lists name of household head, his address, and category.

**D. Administration and Management**

<b>1. Medical Assistance Unit</b>	The Medical Assistance Services Unit is located in the Personal Care Section of the Division of Health and Medical Services. The Director, from the field of public health administration, has a staff consisting of a full-time Medical Social Worker and a part-time Medical Consultant (physician). There is also a full-time claims processing supervisor. Pharmaceutical and dental consultation is available on an on-call basis from other units of the Division. A medical social worker in the Division of Public Assistance and Social Services devotes full-time to the non-medical aspects of the title XIX program.
<b>2. Supervision of Statewide Operations</b>	Supervision of Statewide operations is accomplished through the Division of Public Assistance and Social Services. A full-time Medical Social Worker is employed to work with the Title XIX program. Medical aspects of supervision of Statewide operations are carried out by the Medical Assistance Unit.
<b>3. Advisory Council</b>	The State advisory body for title XIX is known as the Medical Assistance and Services Advisory Committee. It is composed of 14 members appointed by the Governor. There are no ex officio members. Authority for the Committee is statutory.
<b>4. Buy-In Agreement</b>	None.
<b>5. Claims Payment Process</b>	
<b>a. State and Local Agencies</b>	The Division of Health and Medical Services of the State Department of Health and Social Services processes and pays all claims from providers of medical and remedial care and services under the plan.
<b>b. Fiscal Agents</b>	None.
<b>c. Prepaid Capitation Arrangements</b>	None.
<b>d. Payments to Non-Medical Institutions</b>	None.

**E. Financing**

<b>1. Federal Financial Participation</b>	The Federal Medical Assistance percentage for Wyoming as promulgated by the Secretary of Health, Education, and Welfare for the period 7/1/69 to 6/30/71 is 60.38.
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**E. Financing (Continued)**

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2. State/Local Participation	State funds are used to pay 100% of the non-Federal share of program costs of both medical assistance and administration.
3. Source of State Funds	State's share of program costs is derived from appropriations made biennially, specifically for the Medical Assistance program. Unobligated balance may be carried over within the biennium but reverts to the General Fund at the end of each biennium.
4. Deficit Financing	There is no authority for deficit financing; but a request may be made to the State Legislature for a deficit or supplemental appropriation at the beginning of a regular session in January for funds to finish that biennium.

State	Eligibility Agency	Medicaid Agency
Alabama	Department of Pensions and Security 64 North Union Street Montgomery, Alabama 36104	State Board of Health 304 Dexter Avenue Montgomery, Alabama 36104
Arkansas	Same as Medicaid Agency	Department of Public Welfare Post Office Box 1437 Little Rock, Arkansas 72203
California	State Department of Social Welfare 744 P Street Sacramento, California 95814	Department of Health Care Services Human Relations Agency 714 P Street, Office Bldg. No. 8 Sacramento, California 95814
Colorado	Same as Medicaid Agency	Department of Social Services 1600 Sherman Street Denver, Colorado 80203
Connecticut	Same as Medicaid Agency	State Welfare Department 1000 Asylum Avenue Hartford, Connecticut 06105
Delaware	Same as Medicaid Agency	Department of Health and Social Services 3000 Newport Gap Pike Wilmington, Delaware 19808
D.C.	Department of Human Resources 122 C Street, N.W. Washington, D.C. 20001	Department of Human Resources District Building, Room 406 14th & E Streets, NW. Washington, D.C. 20004
Florida	Division of Family Services Department of Health and Rehabilitative Services Post Office Box 2050 Jacksonville, Florida	Department of Health and Rehabilitative Services Room 432 Larsen Building Tallahassee, Florida 32304
Georgia	Georgia Department of Family and Children Services State Office Building Atlanta, Georgia 30334	Department of Public Health 47 Trinity Avenue, S.W. Atlanta, Georgia 30334
Guam	Same as Medicaid Agency	Department of Public Health and Social Services Government of Guam Post Office Box 2816 Agana, Guam 96910
Hawaii	Same as Medicaid Agency	Department of Social Services and Housing Post Office Box 339 Honolulu, Hawaii 96809
Idaho	Same as Medicaid Agency	State Department of Public Assistance Boise, Idaho 83701
Illinois	Same as Medicaid Agency	Department of Public Aid 400 South Spring Street Springfield, Illinois 62706



State	Eligibility Agency	Medicaid Agency
Indiana	Same as Medicaid Agency	Department of Public Welfare State Office Building, Room 701 100 North Senate Avenue Indianapolis, Indiana 46204
Iowa	Same as Medicaid Agency	Department of Social Services Lucas State Office Building Des Moines, Iowa 50319
Kansas	Same as Medicaid Agency	State Department of Social Welfare State Office Building Topeka, Kansas 66612
Kentucky	Same as Medicaid Agency	Department of Economic Security New Capitol Annex Building Frankfort, Kentucky 40601
Louisiana	Same as Medicaid Agency	Department of Public Welfare Post Office Box 44065 Baton Rouge, Louisiana 70804
Maine	Same as Medicaid Agency	Department of Health and Welfare State House Augusta, Maine 04330
Maryland	Social Services Administration 1315 St. Paul Street Baltimore, Maryland 21202	Department of Health 301 West Preston Street Baltimore, Maryland 21201
Massachusetts	Same as Medicaid Agency	Department of Public Welfare 600 Washington Street Boston, Massachusetts 02111  Commission for the Blind 39 Boylston Street Boston, Massachusetts 02116
Michigan	Same as Medicaid Agency	State Department of Social Services Lewis Cass Building Walnut & Washtenaw Street Lansing, Michigan 48913
Minnesota	Same as Medicaid Agency	Department of Public Welfare Centennial Building 658 Cedar Street St. Paul, Minnesota 55101
Mississippi	State Department of Public Welfare P.O. Box 4321, Fondren Station Jackson, Mississippi 39216	Mississippi Medicaid Commission Room 313, Dale Building 2906 N. State Street Jackson, Mississippi 39219
Missouri	Same as Medicaid Agency	Division of Welfare Department of Public Health and Welfare State Office Building Jefferson City, Missouri 65101
Montana	Same as Medicaid Agency	State Department of Public Welfare Helena, Montana 59601

State	Eligibility Agency	Medicaid Agency
Nebraska	Same as Medicaid Agency	Nebraska Department of Public Welfare 1526 K Street, 4th Floor Lincoln, Nebraska 68508
Nevada	Same as Medicaid Agency	Department of Health, Welfare and Rehabilitation 201 South Fall Street Carson City, Nevada 89701
New Hampshire	Same as Medicaid Agency	Department of Health and Welfare State House Annex Concord, New Hampshire 03301
New Jersey	Same as Medicaid Agency	Department of Institutions and Agencies Post Office Box 1237 Trenton, New Jersey 08625
New Mexico	Same as Medicaid Agency	New Mexico Health and Social Services Department Post Office Box 2348 Santa Fe, New Mexico 87501
New York	Same as Medicaid Agency	State Department of Social Services 1450 Western Avenue Albany, New York 12203
North Carolina	Same as Medicaid Agency	State Department of Social Services Education Building Post Office Box 2599 Raleigh, North Carolina 27602
North Dakota	Same as Medicaid Agency	Public Welfare Board of North Dakota Bismarck, North Dakota 58501
Ohio	Same as Medicaid Agency	State Department of Public Welfare 408 East Town Street Columbus, Ohio 43215
Oklahoma	Same as Medicaid Agency	Department of Institutions, Social and Rehabilitative Services Post Office Box 25352 Oklahoma City, Oklahoma 73125
Oregon	Same as Medicaid Agency	State Public Welfare Division 422 Public Service Building Salem, Oregon 97310
Pennsylvania	Department of Public Welfare Health and Welfare Building Harrisburg, Pennsylvania 17120	Department of Public Welfare Health and Welfare Building Harrisburg, Pennsylvania 17120
Puerto Rico	Department of Social Services Post Office Box 9342 Santurce, Puerto Rico 00908	Department of Health Post Office Box 9342 Santurce, Puerto Rico 00908
Rhode Island	Same as Medicaid Agency	Department of Social and Rehabilitative Services 1 Washington Avenue Providence, Rhode Island 02905



State	Eligibility Agency	Medicaid Agency
South Carolina	Same as Medicaid Agency	Department of Public Welfare Post Office Box 1520 Columbia, South Carolina 29202
South Dakota	Same as Medicaid Agency	Department of Public Welfare State Office Building Pierre, South Dakota 57501
Tennessee	State Department of Public Welfare Nashville, Tennessee 37219	Department of Public Health 344 Cordell Hull Building Nashville, Tennessee 37219
Texas	Same as Medicaid Agency	State Department of Public Welfare John H. Reagan Building Austin, Texas 78701
Utah	Division of Family Services Department of Social Services 221 State Capitol Salt Lake City, Utah 84111	Department of Social Services 231 East 4th Street, South Salt Lake City, Utah 84111
Vermont	Same as Medicaid Agency	Department of Social Welfare State Office Building Montpelier, Vermont 05602
Virgin Islands	Department of Social Welfare Charlotte Amalie St. Thomas, Virgin Islands 00801	Department of Health Charlotte Amalie St. Thomas, Virgin Islands 00801
Virginia	State Department of Welfare and Institutions 429 South Belvidere Street Richmond, Virginia 23220  Commission for the Visually Handicapped 3003 Parkwood Avenue Richmond, Virginia 23221	Department of Health 109 Governor Street Richmond, Virginia 23219
Washington	Same as Medicaid Agency	Department of Social and Health Services Post Office Box 1162 Olympia, Washington 98501
West Virginia	Same as Medicaid Agency	Department of Welfare 1800 Washington Street, East Charleston, West Virginia 25305
Wisconsin	Same as Medicaid Agency	Wisconsin Department of Health and Social Services 1 West Wilson Street Madison, Wisconsin 53702
Wyoming	Division of Public Assistance and Social Services Department of Health and Social Services State Office Building Cheyenne, Wyoming 82001	Division of Health and Medical Services Department of Health and Social Services State Office Building Cheyenne, Wyoming 82001

# FEDERAL MEDICAL ASSISTANCE PERCENTAGES

State	Promulgated for the following periods —			
	1/1/66—6/30/67	7/1/67—6/30/69	7/1/69—6/30/71	7/1/71—6/30/73
Alabama	79.85	78.60	78.54	78.43
Alaska*	50.00	50.00	50.00	50.00
Arizona*	63.94	64.99	66.42	64.15
Arkansas	81.67	79.81	79.76	79.42
California	50.00	50.00	50.00	50.00
Colorado	53.08	55.31	56.24	57.61
Connecticut	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	50.00	50.00
District of Columbia	50.00	50.00	50.00	50.00
Florida	65.21	65.09	64.10	60.67
Georgia	74.91	72.85	71.48	69.67
Guam	55.00	55.00	50.00	50.00
Hawaii	52.97	50.00	50.75	50.83
Idaho	70.73	67.87	68.91	71.56
Illinois	50.00	50.00	50.00	50.00
Indiana	55.77	53.39	52.85	55.05
Iowa	60.39	59.60	55.27	58.07
Kansas	61.45	57.90	57.78	59.06
Kentucky	76.70	75.25	74.30	73.49
Louisiana	76.41	74.58	73.57	73.49
Maine	69.57	69.92	68.33	69.43
Maryland	50.00	50.00	50.00	50.00
Massachusetts	50.00	50.00	50.00	50.00
Michigan	50.31	50.00	50.00	50.00
Minnesota	60.46	58.40	56.95	56.82
Mississippi	83.00	83.00	83.00	83.00
Missouri	53.90	58.40	59.29	59.53
Montana	62.86	64.01	64.72	67.16
Nebraska	60.39	60.48	57.25	58.48
Nevada	50.00	50.00	50.00	50.00
New Hampshire	61.31	60.12	59.18	59.36
New Jersey	50.00	50.00	50.00	50.00
New Mexico	70.73	70.15	71.48	72.63
New York	50.00	50.00	50.00	50.00
North Carolina	75.58	75.30	73.96	72.84
North Dakota	66.67	70.74	70.48	71.28
Ohio	52.33	52.64	52.42	53.65
Oklahoma	70.32	69.61	68.84	69.02
Oregon	54.12	54.37	56.35	57.39
Pennsylvania	54.38	55.03	54.60	55.45
Puerto Rico	55.00	55.00	50.00	50.00
Rhode Island	56.13	52.61	51.70	50.26
South Carolina	81.30	80.50	78.68	78.00
South Dakota	71.05	73.26	69.91	69.69
Tennessee	76.86	76.14	74.62	74.35
Texas	67.27	67.10	66.66	65.18
Utah	66.30	65.24	68.23	69.88
Vermont	68.44	69.00	64.96	64.71
Virgin Islands	55.00	55.00	50.00	50.00
Virginia	66.96	65.85	65.04	64.03
Washington	50.81	50.00	50.00	50.00
West Virginia	74.27	75.84	75.73	76.97
Wisconsin	57.60	56.68	55.21	56.28
Wyoming	55.47	59.20	60.38	62.73

\*Not applicable; no title XIX program.



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